

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 91 05501

1. DECEDENT'S NAME (First, Middle, Last) <b>William L. McFarlane</b>		2. DATE OF DEATH MONTH DAY YEAR <b>2-27-1991</b>		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER <b>214-12-0440</b>		5. SEX <b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>66</b> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <b>May 21, 1924</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>St. Josephs Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Towson</b>		9c. COUNTY OF DEATH <b>Baltimore County</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Howard</b>		10c. CITY, TOWN OR LOCATION <b>Ellicott City</b>	
10d. INSIDE CITY LIMITS? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>10186 Globe Dr.</b>		10f. ZIP CODE <b>21043</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <b>1</b> <input type="checkbox"/> Never Married <b>2</b> <input checked="" type="checkbox"/> Married <b>3</b> <input type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW 2</b>	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>4 years</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Insurance Agent</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Self Employed</b>	
17. FATHER'S NAME (First, Middle, Last) <b>William McFarlane</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Clara Levey</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mrs. Janet H. McFarlane</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10186 Globe Dr. Ellicott City, MD 21043</b>			
20a. METHOD OF DISPOSITION <b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State <b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Druid Ridge Cemetery</b>		20c. LOCATION — City or Town, State <b>Pikesville, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>John K. Syme</b>		22. NAME AND ADDRESS OF FACILITY <b>Loring Byers Funeral Directors, Inc. 8728 Liberty Rd. Randallstown, MD 21133</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>IRREPARABLE AORTIC DISSECTION TAP A</b> <b>MYXOID DEGENERATION ASCENDING AORTA</b> <b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> <b>1 day</b> <b>YEARS</b>		Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Aortic + Mitral Valve Replacement and Double Coronary artery bypass March 1986 St. Josephs.</b>		24a. WAS AN AUTOPSY PERFORMED? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) <b>HOSPITAL:</b> <b>1</b> <input checked="" type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA <b>OTHER:</b> <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation <b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined <b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>GARTH R McDONALD Surgeon</b>		29c. LICENSE NUMBER <b>D 26151</b>	
29d. DATE SIGNED (Month, Day, Year) <b>2-27-91</b>		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>GARTH R McDONALD CARDIAC SURGERY SAINT JOSEPH HOSPITAL</b>			
31. DATE FILED (Month, Day, Year) <b>MAR 04 1991</b>		32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			





Jeanne Morris

91 05502

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Jeanne Lowe Morris</i>				2. DATE OF DEATH MONTH <i>2</i> DAY <i>19</i> YEAR <i>91</i>		3. TIME OF DEATH <i>9:05 P M</i>	
4. SOCIAL SECURITY NUMBER <i>221-09-4153</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>85</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>Feb. 2, 1906</i>	
8. BIRTHPLACE (State or Foreign Country) <i>Delaware</i>				9a. FACILITY NAME (If not institution, give street and number) <i>SALISBURY NURSING HOME</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>SALISBURY, MD.</i>	
9c. COUNTY OF DEATH <i>WICOMICO</i>				10a. STATE <i>Maryland</i>		10b. COUNTY <i>Wicomico</i>	
10c. CITY, TOWN OR LOCATION <i>Salisbury</i>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <i>1532 Woodridge Drive</i>	
10f. ZIP CODE <i>21801</i>				10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12 yrs.</i> College (1-4 or 5+) <i>2 yrs.</i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Realtor</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Real Estate Sales</i>	
17. FATHER'S NAME (First, Middle, Last) <i>James William Lowe</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Lena Mae Hitchens</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Lavessa Mitchell</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>232 Woodridge Dr., Salisbury MD 21801</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Epworth Methodist Cemetery</i>		20c. LOCATION — City or Town, State <i>Rehoboth Beach, DE</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <i>Parsell, Atkins &amp; Lodge Funeral Homes, Inc. P.O. Box 477, Lewes, DE 19958</i>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Upper Respiratory Infection</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <i>[Blank]</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>[Blank]</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>[Blank]</i> DUE TO (OR AS A CONSEQUENCE OF): d. <i>[Blank]</i>						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Parkinson's Disease, Chronic Antic Acid</i> <i>S/P Gunshot Wound, Occult</i>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Homicide			
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <i>040190</i>		29d. DATE SIGNED (Month, Day, Year) <i>2/20/91</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) <i>Eddie V. Hazzard, MD, Salisbury Medcenter, Salisbury, MD</i>							
31. DATE FILED (Month, Day, Year) <i>MAR 4 1991</i>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 05503

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Julius Ed PIOTROWSKI</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>1</b> YEAR <b>91</b>		3. TIME OF DEATH <b>12:50 a m</b>	
4. SOCIAL SECURITY NUMBER <b>217-03-9406</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>74</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>2-13-17</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Franklin Square Hosp.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Md.</b>		10b. COUNTY <b>Balto.</b>		10c. CITY, TOWN OR LOCATION <b>Balto.</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>4729 Glenarm Ave.</b>				10f. ZIP CODE <b>21206</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Buyer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Md. Cup</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Charles E. Piotrowski</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Josephine</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Margaret A. Piotrowski</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4729 Glenarm Ave. Balto., Md. 21206</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Gardens of Faith</b>		20c. LOCATION — City or Town, State <b>Balto., Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>John C. Miller Inc. 6415 Belair Rd. Balto., Md. 21206</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Adenocarcinoma of lung</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Left lower lobe pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>congestive heart failure</b> DUE TO (OR AS A CONSEQUENCE OF): d. <b>Chronic obstructive pulmonary disease</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypertension</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		26a. DATE OF INJURY (Month, Day, Year)		26b. TIME OF INJURY <b>M</b>		26c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
26d. DESCRIBE HOW INJURY OCCURRED		26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Teresa Hoffman MD</b>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>▶</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Teresa Hoffman MD 9000 Franklin Square Dr. Baltimore, M.D. 21237</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 04 1991</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 05504

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>EDWARD J ROBERTS</b>				2. DATE OF DEATH MONTH <b>2</b> DAY <b>27</b> YEAR <b>91</b>		3. TIME OF DEATH <b>9:20 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>217-14-3833</b>		5. SEX <b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>67</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>10/17/23</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>HARBOR HOSPITAL CENTER</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE, MD</b>		9c. COUNTY OF DEATH <b>BALTIMORE</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>-----</b>		10c. CITY, TOWN OR LOCATION <b>Balto, City, Md.</b>	
10d. INSIDE CITY LIMITS? <b>1</b> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>116 W. Ostend St.</b>			
10f. ZIP CODE <b>21230</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <b>3</b> <input type="checkbox"/> Never Married <b>2</b> <input checked="" type="checkbox"/> Married <b>4</b> <input type="checkbox"/> Widowed <b>5</b> <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10 th, Grade</b> College (1-4 or 5+) <b>-----</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Transit &amp; Traffic</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Balto. City</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Unknown Roberts</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Unknown</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mrs. Loretta A. Roberts</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>116 W. Ostend St. Balto. Md. 21230</b>			
20a. METHOD OF DISPOSITION <b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State <b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>New Cathedral Cemetery</b>		20c. LOCATION — City or Town, State <b>Balto. Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Daniel A. Naylor</b>		22. NAME AND ADDRESS OF FACILITY <b>Balto. Md. 21230 McCully Funeral Home, 130 E. Fort Ave</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>SEPSIS</b> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <b>SMALL CELL CARCINOMA</b> c. <b>ASPIRATION PNEUMONIA</b>							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1</b> <input checked="" type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA OTHER: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation <b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined <b>3</b> <input type="checkbox"/> Suicide <b>7</b> <input type="checkbox"/> Nomicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURED					
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>R. DESAI HOUSE STAFF</b>				29c. LICENSE NUMBER <b>040390</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/27/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>R. DESAI MD, HARBOR HOSPITAL CENTER, 3001 S. HANOVER ST. BALTIMORE, MD</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 04 1991</b>		32. REGISTRAR'S SIGNATURE <b>J. Davidson-Randell</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146


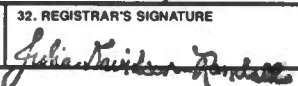
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 05505

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>GERTRUDE E. STOJANOVICH</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>1</b> YEAR <b>91</b>		3. TIME OF DEATH <b>2:30 A M</b>	
4. SOCIAL SECURITY NUMBER <b>212-32-8564</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (in yrs. last birthday) <b>71</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>SEPT. 2, 1919</b>	
8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>				9a. FACILITY NAME (If not institution, give street and number) <b>1131 SARGEANT STREET</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>	
9c. COUNTY OF DEATH							
10a. STATE <b>MARYLAND</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1131 SARGEANT STREET</b>				10f. ZIP CODE <b>21230</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8TH GRADE</b> College (14 or 5+) <b>College (14 or 5+)</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>FACTORY WORKER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>RAY'S ENVELOPE CO.</b>			
17. FATHER'S NAME (First, Middle, Last) <b>ROBERT WHEELER</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>AMELIA BINGLE</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MR. &amp; MRS. RUSSELL STANOVICH</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2622 MARBOURNE AVE., BALTIMORE, MD. 21230</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>LOUDON PARK CEMETERY</b>		DATE <b>3/4</b>		20c. LOCATION — City or Town, State <b>BALTIMORE</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>HUBBARD FUNERAL HOME INC.</b> <b>4107 WILKENS AVENUE, BALTIMORE, MD. 21229</b>			
23. PART I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Myocardial Infarction</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <b>Coronary Artery Disease</b> DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d. Approximate interval between Onset and Death <b>1 hr</b> <b>Years</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Critical Aortic Stenosis</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Andrew A. Ziskind MD</b>				29c. LICENSE NUMBER <b>D39943</b>		29d. DATE SIGNED (Month, Day, Year) <b>3-2-91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Andrew A. Ziskind, MD U. of Maryland Hospital.</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 04 1991</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE POSTING OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				CERTIFICATE OF DEATH				REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last) <b>Thomas L. Sye SR.</b>						2. DATE OF DEATH MONTH <b>02</b> DAY <b>28</b> YEAR <b>91</b>		3. TIME OF DEATH <b>11:25 A M</b>							
4. SOCIAL SECURITY NUMBER <b>218-09-0933</b>			5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>79</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>		7. DATE OF BIRTH (Month, Day, Year) <b>5-4-11</b>		8. BIRTHPLACE (State or Foreign Country) <b>MD</b>		
9a. FACILITY NAME (If not institution, give street and number) <b>BON SECOUR HOSP.</b>						9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE, MD</b>						9c. COUNTY OF DEATH			
10a. STATE <b>MD</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTIMORE, CITY</b>						10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
10e. STREET AND NUMBER <b>1821 LAURETTA AVE.</b>				10f. ZIP CODE <b>21223</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7th</b> College (1-4 or 5+) <b>CHAUFFER</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>MD. OFFICE SUPPLY</b>				16b. KIND OF BUSINESS/INDUSTRY							
17. FATHER'S NAME (First, Middle, Last) <b>CHARLES SYE</b>						18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>CHRISTINE PERRY</b>									
19a. INFORMANT'S NAME (Type/Print) <b>FRANCES McDOWELL</b>						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1821 LAURETTA AVE./BALTIMORE, MD. 21223</b>									
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>ARBUTUS MEMORIAL PARK</b>				20c. LOCATION — City or Town, State <b>ARBUTUS, MD.</b>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Bladine W...</b>						22. NAME AND ADDRESS OF FACILITY <b>WM.C. MARCH F.H. 1101 E. NORTH AVE.</b>									
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Coronary Arrhythmias</b> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <b>Arteriosclerotic Heart Disease</b> c. d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes Mellitus</b> <b>Hypertension</b>												24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <b>Christie Lamping</b>				29c. LICENSE NUMBER <b>D32263</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/28/91</b>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>CHRISTIE LAMPING 101N Payson St Baltimore 21223</b>															
31. DATE FILED (Month, Day, Year) <b>MAR 04 1991</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Bendall</b>											



91 05507

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>William Mac Seward</u>				2. DATE OF DEATH MONTH <u>2</u> DAY <u>28</u> YEAR <u>91</u>		3. TIME OF DEATH <u>9:45 P.M.</u>	
4. SOCIAL SECURITY NUMBER <u>220-20-4122</u>		5. SEX <u>1</u> M <u>2</u> F		6. AGE (In yrs. last birthday) <u>62</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>11-16-28</u>	
8. BIRTHPLACE (State or Foreign Country) <u>MD.</u>				9a. FACILITY NAME (If not institution, give street and number) <u>Francis Scott Key</u>		9b. CITY, TOWN OR LOCATION OF DEATH <u>Balto</u>	
9c. COUNTY OF DEATH				10a. STATE <u>MD.</u>		10b. COUNTY <u>Balto</u>	
10c. CITY, TOWN OR LOCATION <u>Turners Station</u>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <u>117 Fleming Dr.</u>	
10f. ZIP CODE <u>21222</u>				10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>Black</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Ship Hook on</u>		16b. KIND OF BUSINESS/INDUSTRY <u>Steel</u>	
17. FATHER'S NAME (First, Middle, Last) <u>Andrew J. Seward</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Jennie Jones</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Gwendolyn Sutton</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>216 Walnut Ave Balto., Md. 21222</u>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Arbutus</u>		20c. LOCATION — City or Town, State <u>Balto., Md.</u>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>James A. Morton</u>				22. NAME AND ADDRESS OF FACILITY <u>James A. Morton &amp; Sons</u> <u>1701 Laurens St. Balto., Md. 21217</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Anoxic Brain Injury</u> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <u>Hypoglycemia</u> DUE TO (OR AS A CONSEQUENCE OF): <u>electromechanical dissociation</u> DUE TO (OR AS A CONSEQUENCE OF):						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>diabetes, nephrotic syndrome.</u>						24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO						26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		28g. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Paul A. [Signature] MD</u>				29c. LICENSE NUMBER <u>D3822</u>		29d. DATE SIGNED (Month, Day, Year) <u>2/18/91</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) <u>MAR 04 1991</u>				32. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 05508

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Singleton, Carol C</i>		2. DATE OF DEATH MONTH <i>3</i> DAY <i>2</i> YEAR <i>91</i>		3. TIME OF DEATH <i>12:30 A</i> M	
4. SOCIAL SECURITY NUMBER <i>239-68-9777</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>45</i> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <i>9-27-45</i>		8. BIRTHPLACE (State or Foreign Country) <i>N.C.</i>			
9a. FACILITY NAME (If not institution, give street and number) <i>University of MD Hospital</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore MD</i>		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT					
10a. STATE <i>MD</i>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <i>Balto.</i>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
10e. STREET AND NUMBER <i>1701 E North Ave #110</i>		10f. ZIP CODE <i>21213</i>		10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) <i>(2)</i> College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Disable</i>		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <i>Joseph P. Russell</i>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Helen B. Miller</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Gina Russell</i>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1701 E North Ave. 21213</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <i>King Mem Park</i>		20c. LOCATION — City or Town, State <i>Balto. Co., Md.</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Jeff Miller F.H.</i>		22. NAME AND ADDRESS OF FACILITY <i>1639 N. Broadway</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Multiple Myeloma</i>  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF):  b. DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d. DUE TO (OR AS A CONSEQUENCE OF):					Approximate Interval Between Onset and Death <i>6 yrs.</i>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Thrombocytopenia</i> <i>Renal Failure</i> <i>Anemia</i>					24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
					24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John Portelli M.D.</i>		29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <i>3/2/91</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>22 South Greene St. Baltimore MD, John Portelli M.D.</i>					
31. DATE FILED (Month, Day, Year) <i>MAR 04 1991</i>		32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



**STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH**

91 05509

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Howard A. Schmidt</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>2</b> YEAR <b>91</b>		3. TIME OF DEATH <b>3:30 P.</b> M		
4. SOCIAL SECURITY NUMBER <b>215-03-0525</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>76</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>5-15-14</b>		8. BIRTHPLACE (State or Foreign Country) <b>Md.</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Inns of Evergreen - Northeast</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Balto.</b>		9c. COUNTY OF DEATH		
10a. STATE <b>Md.</b>				10b. COUNTY <b>Balto.</b>		10c. CITY, TOWN OR LOCATION <b>Balto.</b>		
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>4404 Glenarm Ave.</b>		10f. ZIP CODE <b>21206</b>		
10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>				11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>W.W. II</b>		
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>9</b> Elementary/Secondary (9-12) <b>College (1-4 or 5+)</b>		
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Linoleum - Tile</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Arts Craft</b>				
17. FATHER'S NAME (First, Middle, Last) <b>Morrison Schmidt</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Anna Didszoneit</b>				
19a. INFORMANT'S NAME (Type/Print) <b>Ruth V. Schmidt</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4404 Glenarm Ave. Balto., Md. 21206</b>				
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Gardens of Faith</b>		20c. LOCATION — City or Town, State <b>Balto., Md.</b>		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>John C. Miller Inc. 6415 Belair Rd. Balto., Md. 21206</b>				
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Hepatic Coma</b>  Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Cirrhosis of the Liver</b>  DUE TO (OR AS A CONSEQUENCE OF): a. <b>Hepatic Coma</b> b. <b>Cirrhosis of the Liver</b> c. d.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Alzheimer's Disease</b>							Approximate Interval Between Onset and Death <b>hours</b> <b>months</b>	
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO				
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <b>Albert B. Bradley M.D.</b>		29c. LICENSE NUMBER <b>D00426</b>		
29d. DATE SIGNED (Month, Day, Year) <b>MARCH 3, 1991</b>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>ALBERT B. BRADLEY, M.D. 4900 BELAIR ROAD BALTIMORE, MARYLAND 21206</b>				
31. DATE FILED (Month, Day, Year) <b>MAR 04 1991</b>				32. REGISTRAR'S SIGNATURE 				

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				91 05510							
1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH				3. TIME OF DEATH							
GILBERT G. SCHMIDT				02 28 1991				11 P M							
4. SOCIAL SECURITY NUMBER		5. SEX		8. AGE (In yrs. last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		7. DATE OF BIRTH		8. BIRTHPLACE (State or Foreign Country)			
21209 3484		M 2 F		70 YRS.		MONTHS DAYS		HOURS MIN.		02-23-21		Md.			
9a. FACILITY NAME (If not institution, give street and number)						9b. CITY, TOWN OR LOCATION OF DEATH				9c. COUNTY OF DEATH					
Good Samaritan Hosp.						Balto.									
10a. STATE				10b. COUNTY				10c. CITY, TOWN OR LOCATION				10d. INSIDE CITY LIMITS?			
Md.								Balto.				1 X YES 2 NO			
10e. STREET AND NUMBER						10f. ZIP CODE				10g. CITIZEN OF WHAT COUNTRY?					
4524 Parkside Dr.						21206				USA					
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES?		13. WAS DECEDENT OF HISPANIC ORIGIN?		14. RACE		15. DECEDENT'S EDUCATION		16a. DECEDENT'S USUAL OCCUPATION		16b. KIND OF BUSINESS/INDUSTRY			
1 Never Married 2 X Married 3 Widowed 4 Divorced		1 X YES 2 NO IF YES, GIVE WAR OR DATES		1 YES 2 NO Specify:		Specify: White		Elementary/Secondary (0-12) College (1-4 or 5+) 2		Insurance Comm.		State of Md.			
17. FATHER'S NAME (First, Middle, Last)						18. MOTHER'S NAME (First, Middle, Maiden Surname)									
Rudolph Schmidt						Edna E. Moore									
19a. INFORMANT'S NAME (Type/Print)						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)									
Jean L. Schmidt						4524 Parkside Dr. Balto., Md. 21206									
20a. METHOD OF DISPOSITION		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)		20c. LOCATION — City or Town, State		21. SIGNATURE OF FUNERAL SERVICE LICENSEE		22. NAME AND ADDRESS OF FACILITY		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.		Approximate Interval Between Onset and Death			
1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		Parkwood Cem.		Balto., Md.		John C. Miller Inc. 6415 Belair Rd. Balto., Md. 21206									
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. ADULT RESPIRATORY DISTRESS SYNDROME.		b. SEPSIS AND DIC.		c. ACUTE INTESTINAL PERFORATION.									
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		d.													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED?		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?							
CARCINOMA OF LUNG RENAL FAILURE.						1 YES 2 X NO		1 YES 2 NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEATH (Check only one)		27. MANNER OF DEATH		28a. DATE OF INJURY		28b. TIME OF INJURY		28c. INJURY AT WORK?		28d. DESCRIBE HOW INJURY OCCURRED			
1 YES 2 X NO		HOSPITAL: 1 X Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)		1 X Natural 5 Pending Investigation 2 Accident 3 Suicide 4 Homicide 8 Could not be determined		(Month, Day, Year)		M		1 YES 2 NO					
						28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28t. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER		29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year)									
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		Resident Dr.		D40496		2/28/91									
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)						31. DATE FILED (Month, Day, Year)						32. REGISTRAR'S SIGNATURE			
PRADIP SHAH, M.D. GOOD SAMARITAN HOSP. BALTIMORE MD.						MAR 04 1991						John Davidson			



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05511

1. DECEDENT'S NAME (First, Middle, Last) HOWARD L. SEEBO (HOWARD L. SEEBO)		2. DATE OF DEATH MONTH DAY YEAR 02 25 91		3. TIME OF DEATH 4:30 a M	
4. SOCIAL SECURITY NUMBER 215-09-1600		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 76 YRS.	
7. DATE OF BIRTH (Month, Day, Year) March 5, 1914		8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not institution, give street and number) NORTH ARUNDEL HOSPITAL ASSOCIATION		9b. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE		9c. COUNTY OF DEATH AA	
RESIDENCE OF DECEDENT					
10a. STATE Maryland		10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Pasadena	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 2172 Lake Drive		10f. ZIP CODE 21122	
10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12th. grade 2 years		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) U.S. MILITARY (ARMY)		16b. KIND OF BUSINESS/INDUSTRY U.S. GOVERNMENT	
17. FATHER'S NAME (First, Middle, Last) Louis		18. MOTHER'S NAME (First, Middle, Maiden Surname) Sebo Etta Brighoff			
19a. INFORMANT'S NAME (Type/Print) Mrs. Dorys E. Seebo		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2172 Lake Drive Pasadena, Maryland 21122			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Lorraine Park Cemetery 2/28		20c. LOCATION — City or Town, State BALTIMORE, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE [Signature]		22. NAME AND ADDRESS OF FACILITY Mc Cully Funeral Home 3204 Mountain Road Pasadena, Md. 21122			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. cardiopulmonary aneot DUE TO (OR AS A CONSEQUENCE OF): b. myocardial infarction DUE TO (OR AS A CONSEQUENCE OF): c. atherosclerotic cardiovascular disease DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death Immed. Immed. Years					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Brain tumor (meningioma)					
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER [Signature]		29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) 2/25/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) IRA E KAPLAN M.D. 7845 OAKWOOD ROAD GLEN BURNIE MARYLAND 21061					
31. DATE FILED (Month, Day, Year) MAR 04 1991		32. REGISTRAR'S SIGNATURE [Signature]			

BROAD  
MAGL 1244 BROAD

100% COTTON

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 91 05512

1. DECEASED'S NAME (First, Middle, Last) <b>CATHERINE SCHWARZ</b>		2. DATE OF DEATH MONTH <b>2</b> DAY <b>26</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>6:55 A M</b>	
4. SOCIAL SECURITY NUMBER <b>217-20-7784</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) <b>84</b> YRS.	
9a. FACILITY NAME (If not institution, give street and number) <b>MERIDIAN NSO CENTER -</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>SEVERNA PARK</b>		9c. COUNTY OF DEATH <b>ANNE ARUNDEL</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Anne Arundel</b>		10c. CITY, TOWN OR LOCATION <b>Pasadena</b>	
10e. STREET AND NUMBER <b>8343 Palm Dr.</b>		10f. ZIP CODE <b>21122</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>College</b>		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Domestic</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Jacob Dausch</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Anna Sauer</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Herman P. Schwarz</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8343 Palm Dr., Pasadena, MD 21122</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Most Holy Redeemer Cemetery</b>		20c. LOCATION — City or Town, State <b>Baltimore, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Stephen D. Schumacher</i>		22. NAME AND ADDRESS OF FACILITY <b>McCully Funeral Home of Pasadena Pasadena, MD., 3204 Mountain Rd. 21122</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Cardiorespiratory arrest</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <b>Broncho pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>ASCVD</b> DUE TO (OR AS A CONSEQUENCE OF): d. <b>CVA</b>					Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>arteriosclerosis</b>					24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Michael Combs MD</i>				29c. LICENSE NUMBER <b>022206</b>	
29d. DATE SIGNED (Month, Day, Year) <b>2-28-91</b>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) <b>273 B Peninsular Farm Rd Arnold MD 21012</b>					
31. DATE FILED (Month, Day, Year) <b>MAR 04 1991</b>		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 91 05513

1. DECEDENT'S NAME (First, Middle, Last) THERESA ESTELLE THOMPSON				2. DATE OF DEATH MONTH DAY YEAR 2-28-91		3. TIME OF DEATH 1600 M				
4. SOCIAL SECURITY NUMBER 215-24-8826		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 63 YRS.		7. DATE OF BIRTH (Month, Day, Year) MARCH 7, 1927		8. BIRTHPLACE (State or Foreign Country) BALTIMORE		
9a. FACILITY NAME (If not institution, give street and number) ST. AGNES HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE			9c. COUNTY OF DEATH			
10a. STATE MARYLAND		10b. COUNTY		10c. CITY, TOWN OR LOCATION BALTIMORE			10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER 2014 WILHELM STREET				10f. ZIP CODE 21223		10g. CITIZEN OF WHAT COUNTRY? U.S.A.				
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th GRADE		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) BINDERY		16b. KIND OF BUSINESS/INDUSTRY BALTIMORE BUSINESS FORMS						
17. FATHER'S NAME (First, Middle, Last) JOHN WALTER DICUS				18. MOTHER'S NAME (First, Middle, Maiden Surname) THERESA KELLER						
19a. INFORMANT'S NAME (Type/Print) ROBERT SHORE				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1937 LEMMON STREET, BALTIMORE, MD. 21223						
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Meadowridge Memorial Park		20c. LOCATION — City or Town, State Baltimore						
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Theresa L. Gott</i>		22. NAME AND ADDRESS OF FACILITY HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE, BALTIMORE, MD. 21229								
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Cardiopulmonary Arrest RT</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Lung CA with Intracranial Metastasis</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER <i>D. Brown</i> MEDICAL RESIDENT				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) Feb 28-1991				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BIKRAM S. JOHAR ; ST AGNES HOSP, 900 CATON AVENUE BALTO.										
31. DATE FILED (Month, Day, Year) Feb 28-1991		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rendell</i>								





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as required by the permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05514

1. DECEDENT'S NAME (First, Middle, Last) <b>Curt G. Thieme</b>		2. DATE OF DEATH MONTH <b>2</b> DAY <b>25</b> YEAR <b>91</b>		3. TIME OF DEATH <b>1259</b> M	
4. SOCIAL SECURITY NUMBER <b>334-18-1237</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>86</b> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <b>10/09/04</b>		8. BIRTHPLACE (State or Foreign Country) <b>Germany</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Mercy Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH <b>N/A</b>	
10a. STATE <b>Md.</b>		10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>124 W. Franklin St., Apt. 1213, Basilica Pl.</b>		10f. ZIP CODE <b>21201</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+) <b>2</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Retired</b>		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <b>Unknown</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Unknown</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Gertrude Warner</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3527 Falls Rd., Balto., Md. 21211</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Loudon Park Crematory</b>		20c. LOCATION — City or Town, State <b>Baltimore, Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Gary L. Kaufman</b>		22. NAME AND ADDRESS OF FACILITY <b>Gary L. Kaufman Funeral Home 5695 Main St., Elkridge, Md. 21227</b>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Possible Sepsis</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF): <b>Cellulitis</b>  b. DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d. DUE TO (OR AS A CONSEQUENCE OF):		Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)  28b. TIME OF INJURY  28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>[Signature]</b>		29c. LICENSE NUMBER	
29d. DATE SIGNED (Month, Day, Year) <b>2/25/91</b>		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>301 S. Park Pl. Balto. MD 21202</b>			
31. DATE FILED (Month, Day, Year) <b>MAR 4 1991</b>		32. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

1. The first part of the report is devoted to a general  
description of the project and its objectives. It is  
followed by a detailed account of the methods used in the  
study. The results of the study are then presented in  
the form of tables and graphs. The final part of the  
report is a discussion of the results and their  
implications for the field of study.

2. The second part of the report is devoted to a  
detailed account of the methods used in the study. It  
describes the experimental design, the subjects used,  
the materials used, and the procedures used. It also  
describes the data collection and analysis methods.

3. The third part of the report is devoted to the  
presentation of the results of the study. It includes  
tables of data, graphs of results, and a detailed  
discussion of the findings. The results are compared  
with those of previous studies and the implications for  
the field of study are discussed.

4. The fourth part of the report is devoted to a  
discussion of the results and their implications for the  
field of study. It discusses the strengths and  
limitations of the study and suggests directions for  
future research.

REG. NO.

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

Best Change

X

X

X

X

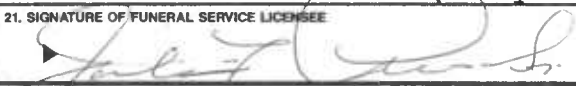


X

WILLIAM J. BROWN

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				91 05516	
CERTIFICATE OF DEATH				REG. NO.					
1. DECEDENT'S NAME (First, Middle, Last) <b>BERNADETTE TILL</b>				2. DATE OF DEATH MONTH DAY YEAR <b>02 28 91</b>		3. TIME OF DEATH <b>8:05 P M</b>			
4. SOCIAL SECURITY NUMBER <b>213-30-2288</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>57</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>03/26/33</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>St. Agnes Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>		9c. COUNTY OF DEATH <b>Baltimore</b>			
10a. STATE <b>MD</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER <b>4450 Norfen Road 21227</b>				10f. ZIP CODE <b>21227</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>0-11</b> College (14 or 5+) <b>-----</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Aide</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Nursing</b>					
17. FATHER'S NAME (First, Middle, Last) <b>Edward Finneran</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Evelyn Naff</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Mr. John Till</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4450 Norfen Road Baltimore, Md. 21227</b>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Maryland Veterans Cemetery</b>		20c. LOCATION — City or Town, State <b>Crownsville, Maryland</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Ambrose Funeral Home, Inc. 1328 Sulphur Spring Road 21227</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ACUTE MYOCARDIAL INFARCTION</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>OCCLUSIVE THROMBUS, RIGHT CORONARY ARTERY, RECENT</b> DUE TO (OR AS A CONSEQUENCE OF):  <b>BRONCHOPNEUMONIA, CONFLUENT, RIGHT AND LEFT UPPER LOBES OF LUNG</b>								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>BRONCHOPNEUMONIA, CONFLUENT, RIGHT AND LEFT UPPER LOBES OF LUNG</b>								24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER  <b>Michael E. Pelczar MD</b>				29c. LICENSE NUMBER <b>D09990</b>		29d. DATE SIGNED (Month, Day, Year) <b>03/01/91</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MICHAEL E. PELCZAR, M.D. ST. AGNES HOSPITAL 900 S. Caton Avenue 21229</b>									
31. DATE FILED (Month, Day, Year) <b>MAR 04 1991</b>				32. REGISTRAR'S SIGNATURE 					



ITEM:7 per FH  
G-674 4/8/91 cm

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 91 05517

1. DECEDENT'S NAME (First, Middle, Last) <b>CHARLES EMMANUEL VALENTINE</b>		2. DATE OF DEATH MONTH <b>02</b> DAY <b>26</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>11:00 P M</b>	
4. SOCIAL SECURITY NUMBER <b>217-01-9871</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>87</b> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <b>Feb. 8, 1991</b>		8. BIRTHPLACE (State or Foreign Country) <b>Rhode Island</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>CHURCH HOME &amp; HOSPITAL</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>		9c. COUNTY OF DEATH <b>Baltimore City</b>	
10a. STATE <b>MD</b>		10b. COUNTY <b>Baltimore City</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore City</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>2925 McElderry Street</b>		10f. ZIP CODE <b>21205</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>?</b>	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>8 years</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Mechanical Supervisor</b>		16b. KIND OF BUSINESS/INDUSTRY <b>U. S. Army</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Emil Valentine</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Amanda O. Gustasson</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Charles E. Wolf</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1564 Cottage Lane Balto., MD 21205</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Oak Lawn Cemetery</b>		20c. LOCATION — City or Town, State <b>Balto., MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John E. Selon</i>		22. NAME AND ADDRESS OF FACILITY <b>Johnson Funeral Home</b> <b>8521 Loch Raven Blvd. Balto., MD 21204</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death)</b> a. <b>Acute Myocardial Infarction</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Constrictive Heart Failure</b> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		Approximate interval between Onset and Death <b>2 week</b>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Cerebrovascular Accident</b>		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <b>28b. TIME OF INJURY</b> <b>M</b> 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Col. Alaygi M.D.</i>		29c. LICENSE NUMBER <b>D39643</b>	
29d. DATE SIGNED (Month, Day, Year) <b>2/26/91</b>		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Chassan Alaygi 7 Dinsmore Avenue Glen Burnie, 21061</b>			
31. DATE FILED (Month, Day, Year) <b>MAR 4 1991</b>		32. REGISTRAR'S SIGNATURE <i>John T. Anderson</i>			





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				REG. NO.					
CERTIFICATE OF DEATH													
1. DECEASED'S NAME (First, Middle, Last) <b>John C. WACKER</b>				2. DATE OF DEATH MONTH DAY YEAR <b>March 2, 1991</b>				3. TIME OF DEATH <b>12:30 p M</b>					
4. SOCIAL SECURITY NUMBER <b>215 22 4591</b>		5. SEX <b>1 M 2 F</b>		6. AGE (In yrs. last birthday) <b>63</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>March 11 1927</b>		8. BIRTHPLACE (State or Foreign Country) <b>Balto., Md.</b>					
9a. FACILITY NAME (If not institution, give street and number) <b>Franklin Sq. Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Rossville</b>				9c. COUNTY OF DEATH <b>Baltimore County</b>					
10a. STATE <b>Md.</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Middle River</b>				10d. INSIDE CITY LIMITS? <b>1 YES 2 NO</b>					
10e. STREET AND NUMBER <b>1112 Beech Drive</b>				10f. ZIP CODE <b>21220</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
11. MARITAL STATUS <b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <b>1 YES 2 NO</b>		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 YES 2 NO</b>				14. RACE — American Indian, Black, White, etc. <b>White</b>					
15. DECEASED'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 5</b>		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Owner-Operator</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Tavern</b>									
17. FATHER'S NAME (First, Middle, Last) <b>Christian Wacker</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Elizabeth Bohlen</b>									
19a. INFORMANT'S NAME (Type/Print) <b>Dorothy E. Wacker, Wife</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1112 Beech Dr. Baltimore, Md. 21220</b>									
20a. METHOD OF DISPOSITION <b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other) <b>Moreland Memorial Pk.</b>		20c. LOCATION — City or Town, State <b>Baltimore, Md.</b>									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>Bruzdzinski Funeral Home PA 1407 Eastern Ave. Balto., Md. 21221</b>									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pneumonia</b> <b>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> b. <b>Renal Failure</b> c. d. <b>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</b> <b>Insulin Dependent Diabetes Mellitus</b> <b>Hypertension</b> <b>Myocardial Infarction</b> <b>Anemia</b>								24a. WAS AN AUTOPSY PERFORMED? <b>1 YES 2 NO</b>		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1 YES 2 NO</b>			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1 YES 2 NO</b>		26. PLACE OF DEATH (Check only one) <b>HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA</b> <b>OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)</b>		27. MANNER OF DEATH <b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</b>		28a. DATE OF INJURY (Month, Day, Year) <b>28b. TIME OF INJURY M</b> <b>28c. INJURY AT WORK? 1 YES 2 NO</b>		28d. DESCRIBE HOW INJURY OCCURRED <b>28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)</b>					
29a. CERTIFIER (Check only one) <b>1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>								29b. SIGNATURE AND TITLE OF CERTIFIER <b>Gillian Adams MD</b>		29c. LICENSE NUMBER <b>N/A</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/2/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Gillian Adams MD 9000 Franklin Square Dr. Baltom Md. 21237</b>								31. DATE FILED (Month, Day, Year) <b>MAR 04 1991</b>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ROLAND WHITE, Jr.</b>				2. DATE OF DEATH MONTH <b>12</b> DAY <b>23</b> YEAR <b>91</b>		3. TIME OF DEATH <b>1245P</b> M	
4. SOCIAL SECURITY NUMBER <b>577-36-6011</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (in yrs. last birthday) <b>65</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>12/29/25</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>3608 PERRY STREET</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>MT. RAINIER</b>		9c. COUNTY OF DEATH <b>P.G.</b>	
10a. STATE <b>MD</b>		10b. COUNTY <b>PG</b>		10c. CITY, TOWN OR LOCATION <b>MT. RAINIER</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>3608 PERRY STREET</b>				10f. ZIP CODE <b>20712</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6th</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Laborer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Dept. of Public Works</b>			
17. FATHER'S NAME (First, Middle, Last) <b>ROLAND WHITE</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ELEANOR WHITE Pinkney</b>			
19a. INFORMANT'S NAME (Type/Print) <b>WALTER D. WHITE</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9113 So. CHERRY LANE, UPPER MARLBOROUGH, MD 20772</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Forest Hills Mem. Gardens</b>		20c. LOCATION — City or Town, State <b>Clinton, Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Darryl H. Pratt</b>				22. NAME AND ADDRESS OF FACILITY <b>H.S. Washington &amp; Sons, Inc. 4925 Burroughs Ave., N.E.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>MYOCARDIAL INFARCTION</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>ATHEROSCLEROTIC CORONARY ARTERY DISEASE.</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>RENAL DISEASE.</b> DUE TO (OR AS A CONSEQUENCE OF): d.  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Alcoholism</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>Robert F. Larkin, M.D. Deputy Registrar</b>		29c. LICENSE NUMBER <b>D 19815</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/23/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>R. LARKIN, M.D. CER/ 575 MARIN ST. LAUREL, MD 20707</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 4 1991</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-0146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Page 6 may be retained by the attending physician and completely filled in by the funeral director, page 5 should be detached for use in the funeral-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 05520

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Bernard J. Wenner Sr.</b>		2. DATE OF DEATH 2/26/91 MONTH 02 DAY 26 YEAR 91		3. TIME OF DEATH 1239 PM	
4. SOCIAL SECURITY NUMBER 215-03-5471		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs last birthday) 73	
7. DATE OF BIRTH MAY 24, 1917		8. BIRTHPLACE (State or Foreign Country) MARYLAND			
9a. FACILITY NAME (If not institution, give street and number) UNIVERSITY HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		9c. COUNTY OF DEATH --
RESIDENCE OF DECEDENT					
10a. STATE MARYLAND		10b. COUNTY HOWARD		10c. CITY, TOWN OR LOCATION COLUMBIA	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER 10880 OLDE WOODS WAY			10f. ZIP CODE 21044		10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: WHITE					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SALES MANAGER		16b. KIND OF BUSINESS/INDUSTRY GOOD HUMOR ICE CREAM	
17. FATHER'S NAME (First, Middle, Last) LOUIS WENNER			18. MOTHER'S NAME (First, Middle, Maiden Surname) MARGARET McNAMARA		
19a. INFORMANT'S NAME (Type/Print) FLORENCE WENNER (WIFE)			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10880 OLDE WOODS WAY, COLUMBIA, MARYLAND 21044		
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) METRO CREMATORY		20c. LOCATION — City or Town, State CATONSVILLE, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>		22. NAME AND ADDRESS OF FACILITY LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES 5555 TWIN KNOLLS ROAD, COLUMBIA, MD. 21045			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) →  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. dissecting thoraco-abd. aneurysm (presumed rupture) DUE TO (OR AS A CONSEQUENCE OF): b. h/o coronary artery disease DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____					Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____ _____ _____					24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) _____ 28b. TIME OF INJURY M 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED _____ 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) _____	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD UNIVERSITY HOSPITAL, BALTIMORE, MARYLAND		29c. LICENSE NUMBER 073971		29d. DATE SIGNED (Month, Day, Year) 2/26/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) UNIVERSITY HOSPITAL, BALTIMORE, MARYLAND					
31. DATE FILED (Month, Day, Year) MAR 04 1991		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				CERTIFICATE OF DEATH				REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last) <i>John C. Wiland</i>				2. DATE OF DEATH 3/1/91 MONTH 3 DAY 1 YEAR 91				3. TIME OF DEATH 3 AM M							
4. SOCIAL SECURITY NUMBER 213-12-9183		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (in yrs. last birthday) 70 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) SEPT. 3, 1920		8. BIRTHPLACE (State or Foreign Country) MARYLAND			
9a. FACILITY NAME (If not institution, give street and number) LORIN NURSING HOME				9b. CITY, TOWN OR LOCATION OF DEATH COLUMBIA				9c. COUNTY OF DEATH HOWARD							
10a. STATE MARYLAND		10b. COUNTY ALLEGANY		10c. CITY, TOWN OR LOCATION LONACONING				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 1 ROBIN STREET				10f. ZIP CODE 21532				10g. CITIZEN OF WHAT COUNTRY? U.S.A.							
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: WHITE							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 11				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) TEXTILE WORKER				16b. KIND OF BUSINESS/INDUSTRY CELANESE CORPORATION							
17. FATHER'S NAME (First, Middle, Last) JOSEPH WILAND				18. MOTHER'S NAME (First, Middle, Maiden Surname) MARGARET LYDEN											
19a. INFORMANT'S NAME (Type/Print) MICHAEL WAYNE WILAND (BROTHER)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9305 SOARING HILL ROAD, COLUMBIA, MARYLAND 21045											
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) OAK HILL CEMETERY		20c. LOCATION — City or Town, State LONACONING, MARYLAND											
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Leroy M. &amp; Russell C. Witzke</i>				22. NAME AND ADDRESS OF FACILITY LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES 5555 TWIN KNOLLS ROAD, COLUMBIA, MD. 21045											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Coronary Infarction</i> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): <i>CAD with atrial fibrillation</i> c. DUE TO (OR AS A CONSEQUENCE OF): <i>CVA</i> d. DUE TO (OR AS A CONSEQUENCE OF):								Approximate Interval Between Onset and Death							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Idiopathic thrombocytopenia</i>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED							
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)											
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Leroy M. &amp; Russell C. Witzke</i>				29c. LICENSE NUMBER 317107		29d. DATE SIGNED (Month, Day, Year) 3/1/91					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 10840 LITTLE PATUXENT PKY, STE 302, COLUMBIA, MD 21044															
31. DATE FILED (Month, Day, Year) MAR 04 1991				32. REGISTRAR'S SIGNATURE <i>John Davidson</i>											





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last) <b>ARLETTA M. ANDERSON</b>				2. DATE OF DEATH MONTH <b>02</b> DAY <b>15</b> YEAR <b>91</b>		3. TIME OF DEATH <b>2:15 P M</b>			
4. SOCIAL SECURITY NUMBER <b>190-01-5800</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>73</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>May 16, 1917</b>	8. BIRTHPLACE (State or Foreign Country) <b>Pennsylvania</b>				
9a. FACILITY NAME (If not institution, give street and number) <b>Potomac Valley Nursing Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Rockville</b>		9c. COUNTY OF DEATH <b>Montgomery</b>			
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Rockville</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER <b>95 Dawson Avenue, Apt. 414</b>				10f. ZIP CODE <b>20850</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>-</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Draftsman</b>		16b. KIND OF BUSINESS/INDUSTRY <b>University of Maryland</b>					
17. FATHER'S NAME (First, Middle, Last) <b>George Westerman</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Minnie Felsing</b>					
19a. INFORMANT'S NAME (Type/Print) <b>James S. Trees</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>128 Allen Street, Beaver Falls, Pennsylvania 15010</b>					
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Montgomery Crematorium, Inc.</b>		20c. LOCATION — City or Town, State <b>Bethesda, Maryland</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>David E. Perry</b>		M00803		22. NAME AND ADDRESS OF FACILITY <b>Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>METASTATIC UTERINE CANCER</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>MALIGNANT PLEURAL EFFUSION</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>BRONCHIAL OBSTRUCTION BY METASTASIS</b> DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST						Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DIABETES MELLITUS</b> <b>FUNCTIONAL BLADDER OBSTRUCTION--INDWELLING FOLEY</b>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>Jonathan S. Plotzky MD</b>		29c. LICENSE NUMBER <b>D38589</b>		29d. DATE SIGNED (Month, Day, Year) <b>February 15, 1991</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>JONATHAN PLOTSKY, MD 9711 MEDICAL CENTER DRIVE, ROCKVILLE, MD</b>									
31. DATE FILED (Month, Day, Year) <b>FEB 19 '91</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>					

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DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEASED'S NAME (First, Middle, Last) <b>Ruth G. Abernethy</b>				2. DATE OF DEATH MONTH <b>02</b> - DAY <b>16</b> - YEAR <b>91</b>		3. TIME OF DEATH <b>2:50 PM</b>	
4. SOCIAL SECURITY NUMBER <b>577-84-3770</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs., last birthday) <b>93</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>JULY 16, 1897</b>	
8. FACILITY NAME (If not institution, give street and number) <b>SUBURBAN HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BETHESDA</b>		9c. COUNTY OF DEATH <b>MONTGOMERY</b>	
10a. STATE <b>MD.</b>				10b. COUNTY <b>MONTGOMERY</b>		10c. CITY, TOWN OR LOCATION <b>CHEVY CHASE</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>5480 WISCONSIN AVE.</b>			
10f. ZIP CODE <b>20815</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>RET. -ADMINISTRATIVE</b>		16b. KIND OF BUSINESS/INDUSTRY <b>INDUSTRIAL MANUFACTURING</b>			
17. FATHER'S NAME (First, Middle, Last) <b>ALLEN O. GILBERT</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>LINDA MOODY</b>			
19a. INFORMANT'S NAME (Type/Print) <b>ROBERT K. ABERNETHY</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1131 STUART RD., PRINCETON, N.J. 08540</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>PARKLAWN CEMETERY 2/20/91</b>		20c. LOCATION — City or Town, State <b>ROCKVILLE, MD.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>W.W. Chambers</b> M00091				22. NAME AND ADDRESS OF FACILITY <b>W. W. CHAMBERS CO. INC., SILVER SPRING, MD. 20910</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>Septicemia (Staphylococcal)</b> <b>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> <b>Acute Renal Failure</b>						Approximate Interval Between Onset and Death <b>1 week</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Acute Renal Failure</b>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>John F. Gustafson, M.D.</b>		29c. LICENSE NUMBER <b>D15049</b>		29d. DATE SIGNED (Month, Day, Year) <b>Feb. 17, 1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>John F. Gustafson, M.D. 5480 Wisconsin Avenue Chevy Chase, MD. 20815</b>		31. DATE FILED (Month, Day, Year) <b>FEB 19 '91</b>		32. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>			



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, & 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05524

1. DECEDENT'S NAME (First, Middle, Last) <b>Bartlett S. Atwood</b>		2. DATE OF DEATH MONTH <b>02</b> DAY <b>14</b> YEAR <b>91</b>		3. TIME OF DEATH <b>10:40 P M</b>	
4. SOCIAL SECURITY NUMBER <b>032-09-0607</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>81</b> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <b>Jan. 21, 1910</b>		8. BIRTHPLACE (State or Foreign Country) <b>Massachusetts</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Dorchester General Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Cambridge</b>		9c. COUNTY OF DEATH <b>Dorchester</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Barnesville</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>18501 Barnesville Road</b>		10f. ZIP CODE <b>20838</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Lawyer</b>		17. KIND OF BUSINESS/INDUSTRY <b>U.S. Department of Justice</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Perez Atwood</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Pearl Not Available</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Ella N. Atwood</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>18501 Barnesville Rd. Barnesville, Maryland 20838</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Rockville Cemetery</b>		20c. LOCATION — City or Town, State <b>Rockville, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert A. Pumphrey</i> <b>M00198</b>		22. NAME AND ADDRESS OF FACILITY <b>Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiac Arrest</b>  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. <b>Cardiac Arrest</b> DUE TO (OR AS A CONSEQUENCE OF):  b. <b>Atherosclerotic disease</b> DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d. DUE TO (OR AS A CONSEQUENCE OF):				Approximate interval between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>W. Kamsheh</i>		29c. LICENSE NUMBER <b>BK 1061845</b>		29d. DATE SIGNED (Month, Day, Year) <b>February 15, 1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>M.W. Kamsheh 404 Byrn Street Cambridge, MD 21613</b>					
31. DATE FILED (Month, Day, Year) <b>FEB 19 '91</b>		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.


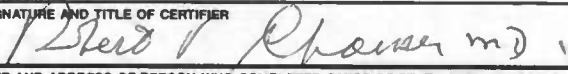
TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05525

1. DECEDENT'S NAME (First, Middle, Last) <b>John B. Armentrout</b>				2. DATE OF DEATH MONTH DAY YEAR <b>February 15, 1991</b>		3. TIME OF DEATH <b>3:00 A M</b>				
4. SOCIAL SECURITY NUMBER <b>219-01-1861</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>76</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>June 7, 1914</b>		8. BIRTHPLACE (State or Foreign Country) <b>Virginia</b>		
9a. FACILITY NAME (If not institution, give street and number) <b>6309 Winston Drive</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Bethesda</b>			9c. COUNTY OF DEATH <b>Montgomery</b>			
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Bethesda</b>			10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER <b>6309 Winston Drive</b>				10f. ZIP CODE <b>20817</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>				
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW 11</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5+</b> College (1-4 or 5+) <b>5+</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Patent Lawyer</b>			16b. KIND OF BUSINESS/INDUSTRY <b>Patent Office</b>			
17. FATHER'S NAME (First, Middle, Last) <b>M.L. Armentrout</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mattie Susan Huffman</b>						
19a. INFORMANT'S NAME (Type/Print) <b>Frances Dahl Armentrout</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6309 Winston Drive Bethesda, Maryland 20817</b>						
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Cedar Hill Cemetery</b>		20c. LOCATION — City or Town, State <b>Suitland, Maryland</b>						
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501</b>						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Carcinoma of the Lung</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>b. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>c. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>d. DUE TO (OR AS A CONSEQUENCE OF):</b>							Approximate Interval Between Onset and Death <b>9 Months</b>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Carcinoma of the Rectum</b> <b>Thrombocytopenia</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)								
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D-13777</b>		29d. DATE SIGNED (Month, Day, Year) <b>February 15, 1991</b>				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Robert V. Choisser, M.D. 5530 Wisconsin Avenue, Chevy Chase, Maryland 20815</b>										
31. DATE FILED (Month, Day, Year) <b>FEB 19 '91</b>				32. REGISTRAR'S SIGNATURE 						





91 05526

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JOSEPH W. ANGYELOF, Sr.</b>				2. DATE OF DEATH MONTH <b>02</b> DAY <b>20</b> YEAR <b>91</b>		3. TIME OF DEATH <b>3:15 A M</b>	
4. SOCIAL SECURITY NUMBER <b>213032065</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>84</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>3-28-06</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Harbor Hospital Center</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>	
9c. COUNTY OF DEATH				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Anne Arundel</b>	
10c. CITY, TOWN OR LOCATION <b>Severna Park</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>676 Michener Ct.</b>	
10f. ZIP CODE <b>21146</b>				10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Carpenter</b>		16b. KIND OF BUSINESS/INDUSTRY <b>American Stores</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Nicholas Angyelof</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Susanne Deitz</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Joseph W. Angyelof, Jr.</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>676 Michener Ct., Severna Park, Maryland 21146</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Glen Haven Memorial Park</b>		20c. LOCATION — City or Town, State <b>Glen Burnie, A.A., MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>Kirkley Funeral Home</b> <b>421 Crain Highway, S.E. Glen Burnie, Maryland 21061</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Metastatic Carcinoma of Liver.</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>R.K. Reen, Intern, HHC, Baltimore</b>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>2/20/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>R.K. Reen, HHC, 3001 S. Hanover St, Baltimore, MD.</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 22 1991</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

91 05527

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>GUDRUN AARSAND</b>				2. DATE OF DEATH MONTH <b>2</b> DAY <b>17</b> YEAR <b>91</b>		3. TIME OF DEATH <b>8:20 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>054-05-9484</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>76</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>9/6/14</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Germany</b>							
9a. FACILITY NAME (If not institution, give street and number) <b>Anne Arundel Medical Ctr.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Annapolis</b>		9c. COUNTY OF DEATH <b>Anne Arundel</b>	
10a. STATE <b>Md.</b>		10b. COUNTY <b>Anne Arundel</b>		10c. CITY, TOWN OR LOCATION <b>Annapolis</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>2900 Shipmaster Way</b>				10f. ZIP CODE <b>21401</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>None</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		15b. KIND OF BUSINESS/INDUSTRY <b>Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Berger Sandvik</b>				15. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Annette Holland</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Knute Aarsand</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1129 Aisquith Dr. Arnold, Md. 21012</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metropolitan Crematory</b>		20c. LOCATION — City or Town, State <b>Alexandria, Va.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert L. Saylor</i>				22. NAME AND ADDRESS OF FACILITY <b>Taylor Funeral Chapel Annapolis, Md.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Renal Failure</b>  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <b>Chronic Hepatitis</b> c. <b>DUE TO (OR AS A CONSEQUENCE OF):</b> d. <b>DUE TO (OR AS A CONSEQUENCE OF):</b>						Approximate Interval Between Onset and Death <b>1-2 years</b> <b>Unk</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Richard I. Hochman, MD</i>		29c. LICENSE NUMBER <b>D5192</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/18/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Richard I. Hochman, MD - 16 Murray Ave, Annapolis, Md 21401</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 19 1991</b>		32. REGISTRAR'S SIGNATURE <i>John Harrison</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DR N. ALBAND

1947-1948

1947-1948

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				REG. NO.							
1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH MONTH DAY YEAR				3. TIME OF DEATH							
Ruth Elizabeth Higgs Aisquith				2-17-1991				6:00A M							
4. SOCIAL SECURITY NUMBER		5. SEX		6. AGE (In yrs. last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHPLACE (State or Foreign Country)			
213-74-6452		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		90 YRS.						3-18-1900		Maryland			
9a. FACILITY NAME (If not institution, give street and number)						9b. CITY, TOWN OR LOCATION OF DEATH				9c. COUNTY OF DEATH					
3355 Aisquith Farm Road						Riva				Anne Arundel					
10a. STATE				10b. COUNTY				10c. CITY, TOWN OR LOCATION				10d. INSIDE CITY LIMITS?			
Md.				Anne Arundel				Riva				1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER						10f. ZIP CODE				10g. CITIZEN OF WHAT COUNTRY?					
3355 Aisquith Farm Road						21140				USA					
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES?		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)		14. RACE — American Indian, Black, White, etc. Specify:									
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		Specify: White									
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced															
15. DECEDENT'S EDUCATION (Specify only highest grade completed)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY							
Elementary/Secondary (0-12) 8				College (1-4 or 5+) Homemaker				Home							
17. FATHER'S NAME (First, Middle, Last)						19. MOTHER'S NAME (First, Middle, Maiden Surname)									
Thomas Joseph Higgs						Susanna Canter									
19a. INFORMANT'S NAME (Type/Print)						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)									
Gertrude A. Singleton						P O Box 103 Riva, Md. 21140									
20a. METHOD OF DISPOSITION				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)				20c. LOCATION — City or Town, State							
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State				Davidsonville Meth. Cem.				Davidsonville, Md.							
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)															
21. SIGNATURE OF FUNERAL SERVICE LICENSEE						22. NAME AND ADDRESS OF FACILITY									
Robert A. Saylor						Taylor Funeral Chapel Annapolis, Md.									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate interval Between Onset and Death			
IMMEDIATE CAUSE (Final disease or condition resulting in death) →															
a. Respiratory Failure															
DUE TO (OR AS A CONSEQUENCE OF):															
b. Persistent Aspiration.															
DUE TO (OR AS A CONSEQUENCE OF):															
c. Organic Brain Syndrome.															
DUE TO (OR AS A CONSEQUENCE OF):															
d.															
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				28. PLACE OF DEATH (Check only one)											
				HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA				OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined															
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one)															
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER						29c. LICENSE NUMBER			29d. DATE SIGNED (Month, Day, Year)						
George P. Sammons						D08314			2/18/91						
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 22) (Type, Print)															
205 Ridgely Ave. Annapolis, MD 21401															
31. DATE FILED (Month, Day, Year)															
FEB 19 1991															



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

91 05529

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Oscar Adams</i>				2. DATE OF DEATH MONTH <i>2</i> DAY <i>3</i> YEAR <i>91</i>		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER <i>218-20-4026</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>66</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>4 23 1924</i>	
8. BIRTHPLACE (State or Foreign Country) <i>md.</i>				9a. FACILITY NAME (If not institution, give street and number) <i>Dorchester General</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Cambridge</i>	
9c. COUNTY OF DEATH <i>Dorchester</i>				10a. STATE <i>md.</i>		10b. COUNTY <i>Dorchester</i>	
10c. CITY, TOWN OR LOCATION <i>Cambridge</i>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <i>615</i>	
10f. ZIP CODE <i>21613</i>				10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>Elem.</i> College (1-4 or 5+) <i>College</i>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>laborer</i>				16b. KIND OF BUSINESS/INDUSTRY <i>truck driver</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Will Adams</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Ernie Adams</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Delores Diaz</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>615 School House Lane Cambridge, Md. 21613</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Washington</i>			
20c. LOCATION — City or Town, State <i>Hurlock, md.</i>				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Tracy Dean</i>			
22. NAME AND ADDRESS OF FACILITY <i>B. S. F. H. P.O. Box 928 Hurlock, md 21643</i>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Decompensated Chronic Obstructive Pulmonary Disease</i>  Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. <i>Diabetes Mellitus</i> DUE TO (OR AS A CONSEQUENCE OF):  b. DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d. DUE TO (OR AS A CONSEQUENCE OF):			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Chronic Debilitated State</i> <i>Chronic Debilitated State</i>				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M			
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Judy Washington, MD</i>			
29c. LICENSE NUMBER <i>D 31108</i>				29d. DATE SIGNED (Month, Day, Year) <i>2/3/91</i>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Judy Washington 802 Collins Ave Hurlock, Md 21643</i>				31. DATE FILED (Month, Day, Year) <i>FEB 7 91</i>			
32. REGISTRAR'S SIGNATURE <i>J. B. ...</i>				33. ADDRESS OF REGISTRAR <i>302 Collins Ave., Hurlock, Md. 21643</i>			





91 05530

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JAMES E. AHERN</b>				2. DATE OF DEATH MONTH DAY YEAR <b>February 12, 1991</b>		3. TIME OF DEATH M <b>6:40 P</b>	
4. SOCIAL SECURITY NUMBER <b>213-24-6022</b>		5. SEX <b>XX M 2 F</b>		6. AGE (In yrs. last birthday) <b>62</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>9/24/28</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Memorial Hospital &amp; Medical Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Cumberland</b>		9c. COUNTY OF DEATH <b>Allegany</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Allebany</b>		10c. CITY, TOWN OR LOCATION <b>Rawlings</b>		10d. INSIDE CITY LIMITS? <b>1 X YES 2 F NO</b>	
10e. STREET AND NUMBER <b>Rt. 3 Box 6</b>				10f. ZIP CODE <b>21557</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>n/a</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>labor</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Lumber</b>			
17. FATHER'S NAME (First, Middle, Last) <b>George Ahern</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Anna Kerns</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Betty Ahern</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Rt. 3 Box 6 Rawlings Md. 21557</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Mt. Olivet Cemetery</b>		20c. LOCATION — City or Town, State <b>Aurora West Va.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Wayne Boal</b>				22. NAME AND ADDRESS OF FACILITY <b>Boal-Warnick Funeral Home Westernport, Md. 21562</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Sepsis</b> DUE TO (OR AS A CONSEQUENCE OF): a. <b>Carcinoma of bladder</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Renal failure</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>Respiratory failure</b> DUE TO (OR AS A CONSEQUENCE OF): d. <b>Respiratory failure</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Dr. Suresh</b>				29c. LICENSE NUMBER <b>D31579</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/14/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Suresh 517 Oldtown Road, Cumberland, MD 21502</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 19 1991</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. Page 6 should be retained by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR  
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05531

1. DECEDENT'S NAME (First, Middle, Last) Catherine C. Blank				2. DATE OF DEATH MONTH DAY YEAR Feb. 13 1991		3. TIME OF DEATH 9:05 A M					
4. SOCIAL SECURITY NUMBER 215-34-4739		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 53 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 20, 1937		8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not institution, give street and number) 3698 Altondale Road				9b. CITY, TOWN OR LOCATION OF DEATH Reisterstown				9c. COUNTY OF DEATH Carroll			
10a. STATE Maryland			10b. COUNTY Carroll		10c. CITY, TOWN OR LOCATION Reisterstown			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 3698 Altondale Road				10f. ZIP CODE 21136		10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) High School College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Supervisor & Housewife		16b. KIND OF BUSINESS/INDUSTRY State of Maryland					
17. FATHER'S NAME (First, Middle, Last) Edward Lynch				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary A. Sandvick							
19a. INFORMANT'S NAME (Type/Print) Philip Blank				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3698 Altondale Rd. Reisterstown, Md. 21136							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) St. Patrick's Cemetery		20c. LOCATION — City or Town, State Mt. Savage, Md.							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John P. Horn</i>				22. NAME AND ADDRESS OF FACILITY Durst Funeral Home Frostburg, Md. 21532							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Metastatic fallopian tube carcinoma</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):						Approximate Interval Between Onset and Death 2 years					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Intestinal obstruction 2° metastatic disease</i>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						29b. SIGNATURE AND TITLE OF CERTIFIER <i>Joan Sumkin MD</i>		29c. LICENSE NUMBER D32527		29d. DATE SIGNED (Month, Day, Year) 2/13/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JOAN SUMKIN MD 80A PAINTERS MILL RD OWINGS MILLS, MD 21117						31. DATE FILED (Month, Day, Year) FEB 14 1991		32. REGISTRAR'S SIGNATURE <i>Joan Sumkin</i>			



91 05532

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ANNIE H BOWEN</b>				2. DATE OF DEATH MONTH DAY YEAR <b>FEBRUARY 25, 1991</b>		3. TIME OF DEATH <b>0415 a<sup>M</sup></b>	
4. SOCIAL SECURITY NUMBER <b>219 54 3379</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>89</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>March 4, 1901</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. CITY, TOWN OR LOCATION OF DEATH <b>PRINCE FREDERICK</b>		9c. COUNTY OF DEATH <b>CALVERT</b>	
9b. FACILITY NAME (If not institution, give street and number) <b>CALVERT MEMORIAL HOSPITAL</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Calvert</b>	
10c. CITY, TOWN OR LOCATION <b>Prince Frederick</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>1575 Sandy Point Road</b>	
10f. ZIP CODE <b>20678</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>housewife</b>		16b. KIND OF BUSINESS/INDUSTRY <b>home</b>	
17. FATHER'S NAME (First, Middle, Last) <b>William Hall</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Knoxey Foxwell</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Lucille C. Bowen</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1280 Mallard PT. Rd. Prince Frederick, Maryland 20678</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Asbury Cemetery 2 27 91</b>		20c. LOCATION — City or Town, State <b>Prince Frederick MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>B. Brown</b>				22. NAME AND ADDRESS OF FACILITY <b>Rausch Funeral Home 4405 Broomes Island Rd Port Republic MD</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CONGESTIVE HEART FAILURE</b>  Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>ATHEROSCLEROTIC HEART DISEASE</b>  <b>BRONCHO PNEUMONIA</b> <b>CHRONIC RENAL FAILURE</b> <b>SEVERE ORGANIC BRAIN SYNDROME</b>							Approximate Interval Between Onset and Death <b>few years</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>BRONCHO PNEUMONIA</b> <b>CHRONIC RENAL FAILURE</b> <b>SEVERE ORGANIC BRAIN SYNDROME</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>ATMund</b>				29c. LICENSE NUMBER <b>D19427</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/25/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>ANWAR MUNSHI, M.D. PRINCE FREDERICK, MARYLAND 20678</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 25 1991</b>				32. REGISTRAR'S SIGNATURE <b>J. Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR:

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05533

1. DECEDENT'S NAME (First, Middle, Last) Lydia A. Brunett				2. DATE OF DEATH MONTH DAY YEAR February 12, 1991				3. TIME OF DEATH 4:55 PM M	
4. SOCIAL SECURITY NUMBER 220-28-5584		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 93 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7. DATE OF BIRTH (Month, Day, Year) Oct. 27, 1897				8. BIRTHPLACE (State or Foreign Country) Maryland					
9a. FACILITY NAME (If not institution, give street and number) Brooke Grove Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Olney				9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT									
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Rockville				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 12 Williams Street				10f. ZIP CODE 20850		10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) 12 College (1-4 or 5+) 12				15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker				15b. KIND OF BUSINESS/INDUSTRY Own Home	
17. FATHER'S NAME (First, Middle, Last) Albert J. Almoney				16. MOTHER'S NAME (First, Middle, Maiden Surname) Miriam Prettyman					
19a. INFORMANT'S NAME (Type/Print) Linda A. Brunett				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12 Williams Street, Rockville, Maryland 20850					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) St. Mary's Cemetery				20c. LOCATION — City or Town, State Rockville, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Neil E. Finer M00877				22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Rockville Inc., 300 West Montgomery Avenue Rockville, Maryland 20850-2805					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Alzheimer's Disease</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death 10 yrs.	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Progressive and long term confusion and apathy</u>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
				28d. DESCRIBE NOW INJURY OCCURED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER Donald E. Dillon M.D.					
				29c. LICENSE NUMBER D13832		29d. DATE SIGNED (Month, Day, Year) 12 Feb 91			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Donald E. Dillon, M.D. 2901 Olney-Sandy Spring Road, Olney, Maryland 20832									
31. DATE FILED (Month, Day, Year) FEB 15 '91				32. REGISTRAR'S SIGNATURE John Davidson-Randall					





REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				CERTIFICATE OF DEATH				REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last) <b>CLARENCE E. BRACEBRIDGE</b>				2. DATE OF DEATH MONTH <b>2</b> DAY <b>16</b> YEAR <b>1991</b>				3. TIME OF DEATH <b>7:59 PM</b>							
4. SOCIAL SECURITY NUMBER <b>371-30-4404</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>55</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>		7. DATE OF BIRTH (Month, Day, Year) <b>May 11, 1935</b>		8. BIRTHPLACE (State or Foreign Country) <b>Michigan</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>SHADY GROVE ADVENTIST HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Rockville</b>				9c. COUNTY OF DEATH <b>Montgomery</b>							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Howard</b>		10c. CITY, TOWN OR LOCATION <b>Highland</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
10e. STREET AND NUMBER <b>13415 Arada Court</b>				10f. ZIP CODE <b>20777</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) <b>1-12</b> College (1-4 or 5+) <b>6 years</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Minister</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Church</b>							
17. FATHER'S NAME (First, Middle, Last) <b>Clarence E. Bracebridge</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Rose Cook</b>											
19a. INFORMANT'S NAME (Type/Print) <b>Arline H. Bracebridge</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>13415 Arada Court, Highland, Md. 20777</b>											
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Woodridge Memorial Park</b>				20c. LOCATION — City or Town, State <b>West Columbia, S. Car.</b>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Louis S. Grant</b>				22. NAME AND ADDRESS OF FACILITY <b>Hines/Rinaldi Funeral Home 11800 N.H. Ave., Silver Spring, Md. 20904</b>											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CHRONIC MYELOGENOUS LEUKEMIA WITH MYELOID BLAST TRANSFORMATION</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. <b>DUE TO (OR AS A CONSEQUENCE OF):</b> b. <b>DUE TO (OR AS A CONSEQUENCE OF):</b> c. <b>DUE TO (OR AS A CONSEQUENCE OF):</b> d. <b>DUE TO (OR AS A CONSEQUENCE OF):</b>								Approximate Interval Between Onset and Death <b>26 mos</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ACUTE UPPER GASTROINTESTINAL HEMORRHAGE</b>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED					
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <b>James A. Brown MD</b>				29c. LICENSE NUMBER <b>D07285</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/17/91</b>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>JAMES A BROWN MD 14808 PHYSICIANS LANE #212 ROCKVILLE MD 20850</b>				31. DATE FILED (Month, Day, Year) <b>FEB 19 '91</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>							



91 05536

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Dorothy H. Bletcher</i>				2. DATE OF DEATH MONTH <i>7</i> DAY <i>13</i> YEAR <i>91</i>		3. TIME OF DEATH <i>7:00</i> M	
4. SOCIAL SECURITY NUMBER <i>578-62-8401</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (in yrs. last birthday) <i>89</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>Dec. 10, 1901</i>	
8. BIRTHPLACE (State or Foreign Country) <i>Philippines</i>		9a. FACILITY NAME (If not institution, give street and number) <i>Fox Chase Nursing Home</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Silver Spring</i>		9c. COUNTY OF DEATH <i>Montgomery</i>	
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Montgomery</i>		10c. CITY, TOWN OR LOCATION <i>Silver Spring</i>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <i>105 Fleetwood Terrace</i>				10f. ZIP CODE <i>20910</i>		10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>1-12</i> College (1-4 or 5+) <i>1 year</i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Homemaker</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Own home</i>	
17. FATHER'S NAME (First, Middle, Last) <i>Wilburn D. Hobbs</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Mary Brownfield</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Irvin H. Schick</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>105 Fleetwood Terrace, Silver Spring, Md. 20910</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Fort Lincoln Cemetery 1991-18</i>		20c. LOCATION — City or Town, State <i>Brentwood, Maryland</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael J. Small</i>				22. NAME AND ADDRESS OF FACILITY <i>Hines/Rinaldi Funeral Home 11800 N.H. Avenue, Silver Spring, Md. 20904</i>			
23. PART I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Alzheimer's Disease</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):						Approximate Interval Between Onset and Death <i>None</i>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Atherosclerotic Heart Disease</i>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Joel M. Hansen</i>		29c. LICENSE NUMBER <i>D16859</i>		29d. DATE SIGNED (Month, Day, Year) <i>2/13/91</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Joel M. Hansen MD</i>				4550 Montgomery Ave., #915N Beth. Md. 20814			
31. DATE FILED (Month, Day, Year) <i>FEB 15 '91</i>		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 05537

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

TO BE COMPLETED BY FUNERAL DIRECTOR

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

**TO THE HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. **TO THE FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit certificate. It should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. **IMPORTANT:** If item 28 is marked, or other traumatic event, the medical examiner must be notified at once.

100

25.4



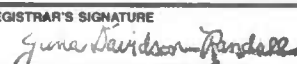
EMOJIA BOWD



91 05538

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Margaret Bertalan</b>		2. DATE OF DEATH MONTH DAY YEAR <b>Febr. 7 1991</b>		3. TIME OF DEATH <b>1:42 A<sup>M</sup></b>	
4. SOCIAL SECURITY NUMBER <b>Unavailable</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>65</b> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <b>Jan. 8, 1926</b>		8. BIRTHPLACE (State or Foreign Country) <b>New Jersey</b>		9a. FACILITY NAME (If not institution, give street and number) <b>Suburban Hospital</b>	
9b. CITY, TOWN OR LOCATION OF DEATH <b>Bethesda</b>		9c. COUNTY OF DEATH <b>Montgomery</b>		10a. STATE <b>Maryland</b>	
10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Rockville</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>10401 Grovenor Place</b>		10f. ZIP CODE <b>20852</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>4</b>		16a. DECEDEENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Teacher</b>	
16b. KIND OF BUSINESS/INDUSTRY <b>High School</b>		17. FATHER'S NAME (First, Middle, Last) <b>Andrew Kosa</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Margaret Blum</b>	
19a. INFORMANT'S NAME (Type/Print) <b>Imre G. Bertalan</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10401 Grovenor Pl., Rockville, Md. 20852</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metropolitan Crematory</b>		20c. LOCATION — City or Town, State <b>Alexandria, Virginia</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY <b>DeVol Funeral Home</b> <b>2222 Wisconsin Ave., NW., Washington, D.C.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>metastatic adenocarcinoma of the duodenum</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.					Approximate Interval Between Onset and Death <b>9 mo</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  					24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
26. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		27. DATE OF INJURY (Month, Day, Year)		28. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28b. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER  MD		29c. LICENSE NUMBER <b>021531</b>	
29d. DATE SIGNED (Month, Day, Year) <b>Feb. 7, 1991</b>		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>G. Peter Pushikas 1510 Old Georgetown Rd. Rockville, Md. 20852</b>			
31. DATE FILED (Month, Day, Year) <b>FEB 14 '91</b>		32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

PAGES 1, 2, 3 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPT. OF HEALTH AND MENTAL HYGIENE PRIOR TO BURIAL, CREMATION, OR REMOVAL.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 05539

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>FLOYD GRANVILLE BUTLER</b>				2. DATE OF DEATH MONTH DAY YEAR <b>FEB. 10, 1991</b>		3. TIME OF DEATH M <b>3:20pm</b>	
4. SOCIAL SECURITY NUMBER <b>225-40-1119</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>70</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>April 4, 1920</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Virginia</b>				9a. FACILITY NAME (If not institution, give street and number) <b>DOCTORS' COMMUNITY HOSPITAL OF P.G.</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>LANHAM SEABROOK</b>	
9c. COUNTY OF DEATH <b>PRINCE GEORGE'S CO.</b>				10a. STATE <b>Md.</b>		10b. COUNTY <b>P.G.</b>	
10c. CITY, TOWN OR LOCATION <b>Greenbelt</b>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>5-G Gardenway Rd.</b>	
10f. ZIP CODE <b>20770</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>W.W. II</b>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) -----				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Foreman</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Embassy Dairy</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Robert Butler</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Lillian Moulden</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Annie R. Butler</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5-G Gardenway Rd. Greenbelt, Md. 20770</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Ft. Lincoln Cemetery</b>		20c. LOCATION — City or Town, State <b>2/15/91 Brentwood, Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Thomas S. Chamber</b> 670				22. NAME AND ADDRESS OF FACILITY <b>W.W. Chambers Co. Inc.</b> <b>5801 Cleveland Ave. Riverdale, Md. 20737</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiac arrest</b>							
DUE TO (OR AS A CONSEQUENCE OF): <b>ASCD</b>							
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide							
28a. DATE OF INJURY (Month, Day, Year)							
28b. TIME OF INJURY M							
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
28d. DESCRIBE HOW INJURY OCCURRED							
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)							
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>J. Granite, MD</b>							
29c. LICENSE NUMBER <b>D17572</b>							
29d. DATE SIGNED (Month, Day, Year) <b>2/12/91</b>							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>David Granite MD 115 Centerway Greenbelt, Md 20770</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 14 '91</b>							
32. REGISTRAR'S SIGNATURE <b>J. Davidson-Randall</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05540

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) <b>HELEN BLACK</b> Helen E. Black				2. DATE OF DEATH MONTH <b>2</b> DAY <b>10</b> YEAR <b>91</b>		3. TIME OF DEATH <b>1:15 A M</b>			
4. SOCIAL SECURITY NUMBER <b>577-20-7128</b>		5. SEX <b>1</b> <input type="checkbox"/> M <b>2</b> <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>89</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>July 8, 1901</b>		8. BIRTHPLACE (State or Foreign Country) <b>Connecticut</b>	
9a. FACILITY NAME (If not Institution, give street and number) <b>SHARON NURSING HOME</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>OLNEY</b>				9c. COUNTY OF DEATH <b>MONTGOMERY</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Olney</b>				10d. INSIDE CITY LIMITS? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>18201 Marden Lane</b>				10f. ZIP CODE <b>20832</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>			
11. MARITAL STATUS <b>1</b> <input type="checkbox"/> Never Married <b>2</b> <input type="checkbox"/> Married <b>3</b> <input checked="" type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Secretary</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Bottling Company</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Oliver Lathrop</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Elizabeth Leahy</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Walter S. Furlow, Jr.</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>#2 Wisconsin Circle, #310, Chevy Chase, MD 20815</b>					
20a. METHOD OF DISPOSITION <b>1</b> <input type="checkbox"/> Burial <b>2</b> <input checked="" type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State <b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Suburban Crematory</b>		20c. LOCATION — City or Town, State <b>Silver Spring, Maryland</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Ellen H. Rapp</b>				22. NAME AND ADDRESS OF FACILITY <b>Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ASPIRATION PNEUMONIA</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>ACUTE ARTERIAL OCCLUSION (R) LEG</b> <b>LEFT HEMISPHERIC CEREBRAL INFARCT</b>						Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ACUTE ARTERIAL OCCLUSION (R) LEG</b> <b>LEFT HEMISPHERIC CEREBRAL INFARCT</b>						24a. WAS AN AUTOPSY PERFORMED? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA OTHER: <b>4</b> <input checked="" type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation <b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined <b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <b>J. Howe, MD</b>				29c. LICENSE NUMBER <b>D33700</b>		29d. DATE SIGNED (Month, Day, Year) <b>2-10-91</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>TED E. HOWE</b> <b>OWNEY, MD.</b>									
31. DATE FILED (Month, Day, Year) <b>FEB 15 '91</b>				32. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>					

100-10000

100-10000

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05541

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) Edward A. Barry, Sr.				2. DATE OF DEATH MONTH DAY YEAR February 14, 1991		3. TIME OF DEATH 9:20 A M	
4. SOCIAL SECURITY NUMBER 083-10-1199		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (in yrs. last birthday) 79 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 8, 1911	
9a. FACILITY NAME (If not institution, give street and number) Suburban Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Bethesda		9c. COUNTY OF DEATH Montgomery	
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Germantown		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 19113 Gunnerfield Lane				10f. ZIP CODE 20874		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 1		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Advertising & Sales		16b. KIND OF BUSINESS/INDUSTRY Newspaper			
17. FATHER'S NAME (First, Middle, Last) Arthur J. Barry, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna McLaughlin			
19a. INFORMANT'S NAME (Type/Print) Anne P. Klein				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19113 Gunnerfield Lane, Germantown, Maryland 20874			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc.		20c. LOCATION — City or Town, State Bethesda, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Barbara J. McMullen Lawrence		M00381		22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cerebrovascular Accident DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Autimmune Hemolytic Anemia Chronic Lymphocytic Leukemia						Approximate Interval Between Onset and Death ~ 24h ~ 2 weeks ~ 2 yrs	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Peripheral Vascular Disease						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) N/A		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) N/A		28e. DESCRIBE HOW INJURY OCCURRED			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Kathryn S. Kirwin MD				29c. LICENSE NUMBER D26992		29d. DATE SIGNED (Month, Day, Year) 2/14/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) KATHRYN S. KIRWIN 10400 Conn. Ave. Kensington MD 20895							
31. DATE FILED (Month, Day, Year) FEB 15 '91		32. REGISTRAR'S SIGNATURE Julia Davidson-Randall					





91 05542

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Winifred Boddie		2. DATE OF DEATH MONTH DAY YEAR February 19, 1991		3. TIME OF DEATH 3:27 A M	
4. SOCIAL SECURITY NUMBER 431-07-8720		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) 88 YRS.	
9a. FACILITY NAME (If not institution, give street and number) 9903 Blundon Drive, #101		9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring		9c. COUNTY OF DEATH Montgomery	
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 9903 Blundon Drive, #101		10f. ZIP CODE 20902	
10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Public Accountant		16b. KIND OF BUSINESS/INDUSTRY Accounting Firm		17. FATHER'S NAME (First, Middle, Last) James Wellborn Granberry	
18. MOTHER'S NAME (First, Middle, Maiden Surname) Carolyn Carlow		19a. INFORMANT'S NAME (Type/Print) Jacquelyn B. Toomey		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9903 Blundon Drive, #101, Silver Spring, MD 20902	
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Suburban Crematory		20c. LOCATION — City or Town, State Silver Spring, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Elan H. Rapp		22. NAME AND ADDRESS OF FACILITY Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → LUNG CANCER a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death	
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER		29c. LICENSE NUMBER D24886	
29d. DATE SIGNED (Month, Day, Year) February 19, 1991		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Mark H. Eig, M. D., 9801 Georgia Avenue, #340, Silver Spring, MD 20902		31. DATE FILED (Month, Day, Year) FEB 19 '91	
32. REGISTRAR'S SIGNATURE Julia Davidson-Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05543

1. DECEDENT'S NAME (First, Middle, Last) Raymond Brecht				2. DATE OF DEATH MONTH DAY YEAR 02-19-91		3. TIME OF DEATH M					
4. SOCIAL SECURITY NUMBER 101-01-5750		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 74 YRS.		7. DATE OF BIRTH (Month, Day, Year) 09-22-16		8. BIRTHPLACE (State or Foreign Country) Brooklyn, NY			
9a. FACILITY NAME (If not institution, give street and number) Anne Arundel Medical Center				9b. CITY, TOWN OR LOCATION OF DEATH Annapolis				9c. COUNTY OF DEATH Anne Arundel			
10a. STATE MD		10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Edgewater				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 861 Severn Avenue				10f. ZIP CODE 21037		10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1941-45		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Lubricator Automobiles		15b. KIND OF BUSINESS/INDUSTRY General Motors, NYC							
17. FATHER'S NAME (First, Middle, Last) Joseph B recht				18. MOTHER'S NAME (First, Middle, Maiden Surname) Marie n/a							
19a. INFORMANT'S NAME (Type/Print) Raymond Brecht				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Collector Lane, Levittown, NY							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Calverton National Cemetery Calverton, NY		20c. LOCATION — City or Town, State							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Patricia J. Arnold		22. NAME AND ADDRESS OF FACILITY Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD									
23. PART I. Enter the disease(s), or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → cardiac arrest Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): CHF and severe COPD b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Julia Davidson-Rendell				29c. LICENSE NUMBER D26743		29d. DATE SIGNED (Month, Day, Year) 2/20/91			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)											
31. DATE FILED (Month, Day, Year) FEB 20 1991											

THE JOURNAL OF THE  
ROYAL ANTHROPOLOGICAL INSTITUTE

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				CERTIFICATE OF DEATH				REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last) <b>Bertie Brown</b>								2. DATE OF DEATH MONTH <b>1</b> DAY <b>26</b> YEAR <b>91</b>				3. TIME OF DEATH <b>5:50 P M</b>			
4. SOCIAL SECURITY NUMBER <b>221-28-1859</b>				5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>90</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>2-28-1900</b>		8. BIRTHPLACE (State or Foreign Country) <b>Delaware</b>					
9a. FACILITY NAME (If not institution, give street and number) <b>Memorial Hospital</b>								9b. CITY, TOWN OR LOCATION OF DEATH <b>Easton</b>				9c. COUNTY OF DEATH <b>Talbot</b>			
10a. STATE <b>Md.</b>				10b. COUNTY <b>Caroline</b>				10c. CITY, TOWN OR LOCATION <b>Denton</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER								10f. ZIP CODE <b>21629</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>Secondary</b> College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY							
17. FATHER'S NAME (First, Middle, Last) <b>Rincer Nichols</b>								18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Sarah Willis</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Geneva Murray</b>								19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Rt #1 Box 584 Bridgeville, De. 19933</b>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Spring Grove</b>				20c. LOCATION — City or Town, State <b>Denton, Md.</b>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Iroy Dean</b>								22. NAME AND ADDRESS OF FACILITY <b>P.O. Box 928 Hurlbut, Md.</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Septicemia</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Probable Perforated Bowel</b> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. b. c. d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Seizure Disorder, Anemia, NIDDM</b> <b>H/O Endometrial CA</b>												Approximate Interval Between Onset and Death			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <b>Rob Lappin MD</b>				29c. LICENSE NUMBER <b>D33294</b>				29d. DATE SIGNED (Month, Day, Year) <b>1/29/91</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Rob Lappin MD Po Box 122 Goldsboro Md. 21636</b>												31. DATE FILED (Month, Day, Year) <b>FEB 14 '91</b>		32. REGISTRAR'S SIGNATURE <b>John L. ...</b>	



91 05545

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) Gilbert Brummell				2. DATE OF DEATH MONTH DAY YEAR 2 11 91		3. TIME OF DEATH 7:25P M	
4. SOCIAL SECURITY NUMBER 218-20-7212		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 82 YRS.		7. DATE OF BIRTH (Month, Day, Year) 5/17/68	
8. BIRTHPLACE (State or Foreign Country) md.		9a. FACILITY NAME (If not institution, give street and number) Meridian The Pines		9b. CITY, TOWN OR LOCATION OF DEATH Easton, Md. 21601		9c. COUNTY OF DEATH Talbot	
RESIDENCE OF DECEASED							
10a. STATE md.		10b. COUNTY Talbot		10c. CITY, TOWN OR LOCATION Easton		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 30 Graham St.		10f. ZIP CODE 21601		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BIK	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input checked="" type="checkbox"/> College (1-4 or 5+)		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Gardner		16b. KIND OF BUSINESS/INDUSTRY Laborer			
17. FATHER'S NAME (First, Middle, Last) George W. Brummel				18. MOTHER'S NAME (First, Middle, Maiden Surname) Sarah E. Camper			
19a. INFORMANT'S NAME (Type/Print) Gustina Roberts				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rt 1 Box 268 Trappe Md. 21673			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Paradise Cem.		20c. LOCATION — City or Town, State Trappe, md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE [Signature]		22. NAME AND ADDRESS OF FACILITY George H. Dashiell Funeral Services, 319 Dover St. Easton					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → RENAL FAILURE							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ORGANIC BRAIN DISEASE HYPERTENSION							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER C. W. Bann				29c. LICENSE NUMBER D00250		29d. DATE SIGNED (Month, Day, Year) 2/12/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 415 E DOVER, EASTON, MD, 21601 [C.W. BANN MD]							
31. DATE FILED (Month, Day, Year) FEB 14 '91		32. REGISTRAR'S SIGNATURE [Signature]					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 7, 2-3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				CERTIFICATE OF DEATH				REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last) Janice B. Blades						2. DATE OF DEATH MONTH 2 DAY 11 YEAR 91		3. TIME OF DEATH 6:30 P M							
4. SOCIAL SECURITY NUMBER 214-30-7604			5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 58 YRS.		7. DATE OF BIRTH (Month, Day, Year) 3/24/32		8. BIRTHPLACE (State or Foreign Country) MD						
9a. FACILITY NAME (If not institution, give street and number) 27 Plum Street						9b. CITY, TOWN OR LOCATION OF DEATH Easton				9c. COUNTY OF DEATH Talbot					
10a. STATE MD		10b. COUNTY Talbot		10c. CITY, TOWN OR LOCATION Easton				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER 27 Plum Street						10f. ZIP CODE 21601		10g. CITIZEN OF WHAT COUNTRY? USA							
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Bookkeeper				16b. KIND OF BUSINESS/INDUSTRY Newspaper							
17. FATHER'S NAME (First, Middle, Last) C. C. Betts, Sr.						18. MOTHER'S NAME (First, Middle, Maiden Surname) Ida Florence Lowe									
19a. INFORMANT'S NAME (Type/Print) John Blades				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Plum Street Easton, MD 21601											
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Eastern Shore Crematory				20c. LOCATION — City or Town, State Georgetown, DE							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE JOHN R. MERCERON				22. NAME AND ADDRESS OF FACILITY Newnam Funeral Home 200 S. Harrison St. Easton, MD											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Breast Cancer</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. c. d. DUE TO (OR AS A CONSEQUENCE OF):										Approximate interval Between Onset and Death 9 YRS					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)											
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER Stephen P. Carney						29c. LICENSE NUMBER 001225				29d. DATE SIGNED (Month, Day, Year) 2-13-91					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Stephen P. Carney 509 Idlewild Ave. Easton, MD 21601															
31. DATE FILED (Month, Day, Year) FEB 13 91				32. REGISTRAR'S SIGNATURE John R. Mercer											



91-0672

ITEMS: 23, 27 per ME  
G-673 3/16/91 cm

91 05547

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) TERRANCE LAMONT BELL, Jr.				2. DATE OF DEATH MONTH 2 DAY 9 YEAR 91		3. TIME OF DEATH 11:26 A M	
4. SOCIAL SECURITY NUMBER none		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) YRS. 2 MONTHS 2 DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) 12-3-90	
8. BIRTHPLACE (State or Foreign Country) Md.				9. FACILITY NAME (If not institution, give street and number) North Arundel Hospital			
10. CITY, TOWN OR LOCATION OF DEATH Glen Burnie				11. COUNTY OF DEATH Anne Arundel			
12a. STATE Md		12b. COUNTY Talbot		12c. CITY, TOWN OR LOCATION Easton		12d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
13. STREET AND NUMBER 303 Dover Brook				14. ZIP CODE 21601		15. CITIZEN OF WHAT COUNTRY? U.S.	
16. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		17. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		18. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		19. RACE — American Indian, Black, White, etc. Specify: Black	
20. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		21. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		22. KIND OF BUSINESS/INDUSTRY			
23. FATHER'S NAME (First, Middle, Last) Terrance Bell Sr.				24. MOTHER'S NAME (First, Middle, Maiden Surname) Brona Brooks			
25. INFORMANT'S NAME (Type/Print) Brona Brooks				26. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 303 Dover Brook Easton, Md 21601			
27a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		27b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Richardson		27c. DATE Easton, Md.		27d. LOCATION — City or Town, State	
28. SIGNATURE OF FUNERAL SERVICE LICENSEE John Prince				29. NAME AND ADDRESS OF FACILITY P.O. Box 925 Hurluck, Md.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>SUDDEN INFANT DEATH SYNDROME</u> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): SEQUENTIALLY list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Ann M. Dixon, M.D., Deputy Chief				29c. LICENSE NUMBER OCME		29d. DATE SIGNED (Month, Day, Year) 2-10-91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Ann M. Dixon, M.D., Deputy Chief 111 Penn Street, Baltimore, MD 21201 vl							
31. DATE FILED (Month, Day, Year) FEB 12 '91		32. REGISTRAR'S SIGNATURE John Davidson-Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

THE UNIVERSITY OF CHICAGO

Handwritten signature and date: 1954

91 05548

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Henry Bretzfield</b>				2. DATE OF DEATH MONTH <b>2</b> DAY <b>15</b> YEAR <b>91</b>		3. TIME OF DEATH <b>4:39 A M</b>	
4. SOCIAL SECURITY NUMBER <b>065-09-6267</b>		5. SEX 1 <input type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>78</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>12-03-12</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Holy Cross Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Silver Spring</b>		9c. COUNTY OF DEATH <b>Montgomery</b>	
10a. STATE <b>MARYLAND</b>				10b. COUNTY <b>MONTGOMERY</b>		10c. CITY, TOWN OR LOCATION <b>ROCKVILLE</b>	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER <b>1202 PARRISH DRIVE</b>				10f. ZIP CODE <b>20851</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>4</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>WRITER/EDITOR</b>		16b. KIND OF BUSINESS/INDUSTRY <b>U.S. DEPT. OF EDUCATION</b>			
17. FATHER'S NAME (First, Middle, Last) <b>GEORGE RUGGLES BRETZFIELD</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>SOPHIA GREENBERG</b>			
19a. INFORMANT'S NAME (Type/Print) <b>ANITA BRETZFIELD (WIFE)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1202 PARRISH DR., ROCKVILLE, MD 20851</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>KING DAVID MEMORIAL GARDEN</b>		20c. LOCATION — City or Town, State <b>FALLS CHURCH, VIRGINIA</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Harry M. Gise</i>				22. NAME AND ADDRESS OF FACILITY <b>DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852</b>			
23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiac-Respiratory Arrest</b>							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
a. <b>Possible Pulmonary Embolism</b>							
b. <b>Intermittent Heart Disease</b>							
c. <b>Heart Block with paroxysms since 1985</b>							
d. <b>Resection Abdominal Aortic Aneurysm</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Heart Block with paroxysms since 1985</b> <b>Resection Abdominal Aortic Aneurysm</b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>none</b>		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Martin L. Lelley, MD</i>				29c. LICENSE NUMBER <b>D06033</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/15/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>2121 Medical Park Drive, S.S., md 20902</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 20 '91</b>		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


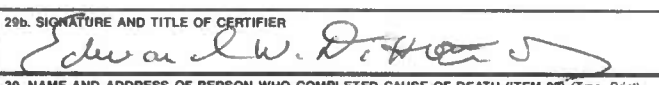
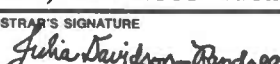
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				CERTIFICATE OF DEATH				REG. NO.							
1. DECEDENT'S NAME (First, Middle, Last) Raymond Lee BOYCE								2. DATE OF DEATH MONTH DAY YEAR February 20, 1991				3. TIME OF DEATH 3:30 A M							
4. SOCIAL SECURITY NUMBER 214-10-4010				5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 83 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Mar. 5, 1907		8. BIRTHPLACE (State or Foreign Country) Virginia					
9a. FACILITY NAME (If not institution, give street and number) Washington County Hospital								9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown				9c. COUNTY OF DEATH Washington							
10a. STATE Maryland				10b. COUNTY Washington				10c. CITY, TOWN OR LOCATION Williamsport				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 2750 Virginia Ave. (B213)								10f. ZIP CODE 21795				10g. CITIZEN OF WHAT COUNTRY? USA							
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Operating Engineer				16b. KIND OF BUSINESS/INDUSTRY Electric Power											
17. FATHER'S NAME (First, Middle, Last) Abner Lee Boyce								18. MOTHER'S NAME (First, Middle, Maiden Surname) Annie L. Clark											
19a. INFORMANT'S NAME (Type/Print) Harry L. Boyce								19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 108 Cranes Crook Lane Annapolis, MD 21401											
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Greenlawn Memorial Park				20c. LOCATION — City or Town, State Williamsport, MD 21795											
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 								22. NAME AND ADDRESS OF FACILITY OSBORNE FUNERAL HOMES P.O. Box # 348 Williamsport, MD 21795											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic Heart Disease (2 prior Myocardial Infarctions) DUE TO (OR AS A CONSEQUENCE OF):  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.												Approximate Interval Between Onset and Death Many Yrs.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Large left subdural hematoma - About 3 weeks												24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA				OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				26. PLACE OF DEATH (Check only one)							
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) ???				28b. TIME OF INJURY ?? M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED Fell at Ravenwood Nursing Home							
				28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) Nursing Home				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 1183 Luther Drive, Hagerstown, Md.											
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																			
29b. SIGNATURE AND TITLE OF CERTIFIER 								29c. LICENSE NUMBER DO1062				29d. DATE SIGNED (Month, Day, Year) Feb. 20, 1991							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Edward W. Ditto, III, M.D., 217 West Washington Street, Hagerstown, Maryland 21740																			
31. DATE FILED (Month, Day, Year) FEB 21 '91				32. REGISTRAR'S SIGNATURE 															





91 05550

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CHARLES CLEMENT BECK JR.				2. DATE OF DEATH MONTH DAY YEAR 2 21 91		3. TIME OF DEATH 8 40 A M	
4. SOCIAL SECURITY NUMBER 184-01-9124		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 72 YRS.		7. DATE OF BIRTH (Month, Day, Year) OCT 21, 1918	
8. BIRTHPLACE (State or Foreign Country) PA.				9a. FACILITY NAME (If not institution, give street and number) Washington County Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown	
9c. COUNTY OF DEATH Washington				10a. STATE MD		10b. COUNTY Washington	
10c. CITY, TOWN OR LOCATION Hagerstown				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 520 W. Franklin St.	
10f. ZIP CODE 21740				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII Korea				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) 0				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) U.S. Army		16b. KIND OF BUSINESS/INDUSTRY Military	
17. FATHER'S NAME (First, Middle, Last) Charles C. Beck Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Emily Delores (UNK)			
19a. INFORMANT'S NAME (Type/Print) Elinor C. Beck				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 520 W. Franklin St., Hagerstown, Md 21740			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Cedar Lawn Memorial Park		20c. LOCATION — City or Town, State Hagerstown, Md	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert B. Rankin				22. NAME AND ADDRESS OF FACILITY Minnich Funeral Home 415 E. Wilson Blvd., Hagerstown, Md 21740			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Carcinoma of lung DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death 8 mos
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Robert McCampbell MD				29c. LICENSE NUMBER D01606		29d. DATE SIGNED (Month, Day, Year) 2/21/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Robert V. L. CAMPBELL HAGERSTOWN MD							
31. DATE FILED (Month, Day, Year) FEB 21 '91				32. REGISTRAR'S SIGNATURE John Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Handwritten notes and a circular stamp in the upper right corner. The stamp contains the letters "H" and "B" and the date "2020".

Handwritten text in the center of the page.

Handwritten text and a circular stamp in the lower right corner. The stamp contains the letters "H" and "B" and the date "2020".

91 05551

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Florence Cornelia Brothers				2. DATE OF DEATH MONTH DAY YEAR Feb. 22, 1991		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER 176-12-4815		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) YRS. 95		7. DATE OF BIRTH (Month, Day, Year) May 2, 1895	
8. BIRTHPLACE (State or Foreign Country) Pennsylvania							
9a. FACILITY NAME (If not institution, give street and number) Washington County Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown		9c. COUNTY OF DEATH Washington	
10a. STATE Maryland		10b. COUNTY Washington		10c. CITY, TOWN OR LOCATION Hagerstown		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 310 East Franklin Street				10f. ZIP CODE 21740		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 years		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		16b. KIND OF BUSINESS/INDUSTRY home			
17. FATHER'S NAME (First, Middle, Last) Finnley Preston Witherup				18. MOTHER'S NAME (First, Middle, Maiden Surname) Emily Cora Graham			
19a. INFORMANT'S NAME (Type/Print) Barbara Cushwa				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 310 East Franklin Street Hagerstown, Maryland 21740			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Rose Hill Cemetery		20c. LOCATION — City or Town, State Hagerstown, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Gerald N. Minnich</i>				22. NAME AND ADDRESS OF FACILITY Gerald N. Minnich 305 N. Potomac Street Funeral Home Hagerstown, Maryland			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>metastatic carcinoma to liver and lung primary unknown</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>R. Guedenet</i>				29c. LICENSE NUMBER D32518		29d. DATE SIGNED (Month, Day, Year) 2.22.91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Robert Guedenet 100 Greeting Lane Keedysville, Md. 21756							
31. DATE FILED (Month, Day, Year) FEB 23 1991 FEB 25 91				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 7, 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				REG. NO.							
1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH				3. TIME OF DEATH							
SUSAN L. BARR				2 16 91				8:40 PM							
4. SOCIAL SECURITY NUMBER		5. SEX		6. AGE (In yrs. last birthday)		7. DATE OF BIRTH		8. BIRTHPLACE (State or Foreign Country)							
215-84-0990		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		29 YRS.		7/14/61		ORLANDO FLA.							
9a. FACILITY NAME (If not institution, give street and number)				9b. CITY, TOWN OR LOCATION OF DEATH				9c. COUNTY OF DEATH							
ANNE ARUNDEL GENERAL HOSP. ANN.MD.				ANAPOLIS				ANNE ARUNDEL CO.							
RESIDENCE OF DECEDENT															
10a. STATE		10b. COUNTY		10c. CITY, TOWN OR LOCATION		10d. INSIDE CITY LIMITS?									
MD.		ANNE ARUNDEL		ANNAPOLIS		1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO									
10e. STREET AND NUMBER				10f. ZIP CODE				10g. CITIZEN OF WHAT COUNTRY?							
50 GENTRY CT.				21403				USA							
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES?		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)		14. RACE — American Indian, Black, White, etc. Specify:									
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		WHITE									
15. DECEDENT'S EDUCATION (Specify only highest grade completed)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY							
Elementary/Secondary (0-12) 12 College (14 or 5+) 5				ENVIROMENTAL PLANNER				STATE OF MARYLAND							
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)											
GEORGE B. LAWRENCE				KATHERINE BOAZ											
19a. INFORMANT'S NAME (Type/Print)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)											
JOHN TIMOTHY BARR				50 GENTRY CT. ANNAPOLIS, MARYLAND 21403											
20a. METHOD OF DISPOSITION		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)		20c. LOCATION — City or Town, State											
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		MT CARMEL CEMETERY		PASADENA, MARYLAND											
21. SIGNATURE OF FUNERAL SERVICE LICENSEE				22. NAME AND ADDRESS OF FACILITY											
[Signature]				3111 MOUNTAIN ROAD STALLINGS FUNERAL HOME PASADENA, MARYLAND											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →								5 days							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST															
a. Cerebral Hemorrhage -															
DUE TO (OR AS A CONSEQUENCE OF):															
b. ARTERIOVENOUS MALFORMATION -															
DUE TO (OR AS A CONSEQUENCE OF):															
c.															
DUE TO (OR AS A CONSEQUENCE OF):															
d.															
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED?							
								1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?							
								1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER?				28. PLACE OF DEATH (Check only one)											
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK?		28d. DESCRIBE HOW INJURY OCCURRED					
1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined						M		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
				28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one)				29b. SIGNATURE AND TITLE OF CERTIFIER								29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year)	
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				[Signature]										2/16/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)															
[Signature] 20 Ridgely Annapolis, MD															
31. DATE FILED (Month, Day, Year)				32. REGISTRAR'S SIGNATURE											
2 FEB 19 1991				[Signature]											



**IMPORTANT:** if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

REG. NO.

91 05553

1. DECEDENT'S NAME (First, Middle, Last) <b>JOSEPHINE C. BROWN</b>				2. DATE OF DEATH 2/18/1991 MONTH DAY YEAR <b>2 - 18 - 91</b>				3. TIME OF DEATH <b>7:10 a.m.</b>							
4. SOCIAL SECURITY NUMBER <b>227-12-0212</b>				5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>76</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>12 02 1915</b>		8. BIRTHPLACE (State or Foreign Country) <b>NORTH DAKOTA</b>					
9a. FACILITY NAME (If not institution, give street and number) <b>Wm. Hill Health Care Center</b>						9b. CITY, TOWN OR LOCATION OF DEATH <b>CAMBRIDGE</b>				9c. COUNTY OF DEATH <b>DORCHESTER</b>					
10a. STATE <b>MD</b>										10b. COUNTY <b>DORCHESTER</b>		10c. CITY, TOWN OR LOCATION <b>CAMBRIDGE</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1011 ROSLYN AVENUE</b>						10f. ZIP CODE <b>21613</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. <b>French Canadian</b> <b>AMERICAN INDIAN</b>							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11th</b> College (1-4 or 5+) _____				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOUSEWIFE</b>				16b. KIND OF BUSINESS/INDUSTRY <b>HOMEMAKER</b>							
17. FATHER'S NAME (First, Middle, Last) <b>FRED JOINVILLE</b>						18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ERNESTINE FAIRBOULT</b>									
19a. INFORMANT'S NAME (Type/Print) <b>MRS. ERNESTINE AARON (DAUGHTER)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3609 KAREN CIRCLE, LINKWOOD, MARYLAND 21835</b>											
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>DORCHESTER MEMORIAL PARK</b>				20c. LOCATION — City or Town, State <b>CAMBRIDGE, MARYLAND</b>									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ernestine Aaron</i>				22. NAME AND ADDRESS OF FACILITY <b>CURRAN FUNERAL HOME</b> <b>308 HIGH STREET, CAMBRIDGE, MD. 21613</b>											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. DIFFUSE LARGE CELL LYMPHOMA</b> <b>DUE TO (OR AS A CONSEQUENCE OF):</b>										Approximate Interval Between Onset and Death <b>9 mo</b>					
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. <b>DUE TO (OR AS A CONSEQUENCE OF):</b> c. <b>DUE TO (OR AS A CONSEQUENCE OF):</b> d. <b>DUE TO (OR AS A CONSEQUENCE OF):</b>															
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>/</i>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED							
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Michael A. Moskewicz MD.</i>						29c. LICENSE NUMBER <b>D-16609</b>		29d. DATE SIGNED (Month, Day, Year) <b>2-18-91</b>							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MICHAEL A. MOSKEWICZ MD. 503 BAYEN ST. CAMBRIDGE MD 21613</b>															
31. DATE FILED (Month, Day, Year) <b>FEB 19 91</b>				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>											





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05554

1. DECEDENT'S NAME (First, Middle, Last) <b>Charles Edward Brummell</b>				2. DATE OF DEATH MONTH DAY YEAR <b>February 6 1991</b>		3. TIME OF DEATH <b>2:59AM</b>	
4. SOCIAL SECURITY NUMBER <b>215-38-1371</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>63</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Apr. 5, 1927</b>	
8. BIRTHPLACE (State or Foreign Country) <b>MD.</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Memorial Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Easton</b>	
9c. COUNTY OF DEATH <b>Talbot</b>				10a. STATE <b>MD.</b>		10b. COUNTY <b>Talbot</b>	
10c. CITY, TOWN OR LOCATION <b>Trappe</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>Box 88 Barber Rd.</b>	
10f. ZIP CODE <b>21154</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (14 or 5+) <input type="checkbox"/>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <b>Arthur Brummell</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Eleanor Camper</b>			
19a. INFORMANT'S NAME (Type/Print) <b>John Brummell</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Box 88 Trappe MD.</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Paradise Ceme.</b>		20c. LOCATION — City or Town, State <b>Trappe MD.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Janelle C. Hery Buck</b>				22. NAME AND ADDRESS OF FACILITY <b>Herry Funeral Home Camb. MD.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Probable Massive Intracerebral Bleed</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Cardiopulmonary Arrest</b> <b>COPD</b>						Approximate Interval Between Onset and Death <b>Hrs</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <b>[Signature]</b>		29c. LICENSE NUMBER <b>DO 5874</b>	
29d. DATE SIGNED (Month, Day, Year) <b>2/6/91</b>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)			
31. DATE FILED (Month, Day, Year) <b>FEB 19 '91</b>				32. REGISTRAR'S SIGNATURE <b>[Signature]</b>			



DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE											
CERTIFICATE OF DEATH											
REG. NO.											
1. DECEDENT'S NAME (First, Middle, Last) <i>Joseph E. Clark, Jr.</i>				2. DATE OF DEATH MONTH <i>2</i> DAY <i>15</i> YEAR <i>91</i>		3. TIME OF DEATH <i>6:30 P.M.</i>					
4. SOCIAL SECURITY NUMBER <i>579-20-9711</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <i>66</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) <i>DEC. 17, 1924</i>			
8. BIRTHPLACE (State or Foreign Country) <i>MARYLAND</i>				9a. FACILITY NAME (If not institution, give street and number) <i>HOLY CROSS HOSPITAL</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>SILVER SPRING</i>			
9c. COUNTY OF DEATH <i>MONTGOMERY</i>				10a. STATE <i>MARYLAND</i>				10b. COUNTY <i>MONTGOMERY</i>			
10c. CITY, TOWN OR LOCATION <i>WHEATON</i>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <i>2627 WEISMAN ROAD</i>			
10f. ZIP CODE <i>20902</i>				10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>				11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced			
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <i>WW II</i>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <i>WHITE</i>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>College</i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>PLUMBER</i>				16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <i>JOSEPH E. CLARK, SR.</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>MARY CALLAHAN</i>							
19a. INFORMANT'S NAME (Type/Print) <i>ANNE KERSEY (COUSIN)</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>10311 PEBBLEBROOK PLACE RICHMOND, VIRGINIA 23233</i>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>GATE OF HEAVEN CEMETERY</i>				20c. LOCATION — City or Town, State <i>SILVER SPRING, MARYLAND</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <i>FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W. SIL. SPR., MD. 20901</i>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Hypovolemic Shock.</i>  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>Upper Gastrointestinal Bleeding</i>  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Pneumonia</i>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <i>208546</i>		29d. DATE SIGNED (Month, Day, Year) <i>2-15-91</i>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>John T. Barber 8208 W. SCOTLAND AVE Bethesda</i>											
31. DATE FILED (Month, Day, Year) <i>FEB 19 '91</i>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>							





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05556

1. DECEDENT'S NAME (First, Middle, Last) <b>James Collins</b>				2. DATE OF DEATH MONTH DAY YEAR <b>02 08 91</b>		3. TIME OF DEATH <b>1:45 a M</b>			
4. SOCIAL SECURITY NUMBER <b>216-07-5990</b>		5. SEX <b>1 M 2 F</b>		6. AGE (In yrs. last birthday) <b>86</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Nov. 5, 1904</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Montgomery General Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Olney</b>			9c. COUNTY OF DEATH <b>Montgomery</b>		
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Silver Spring</b>			10d. INSIDE CITY LIMITS? <b>1 YES 2 NO</b>		
10e. STREET AND NUMBER <b>14925 Pennfield Circle</b>				10f. ZIP CODE <b>20906</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 YES 2 NO</b> IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 YES 2 NO Specify:</b>			14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Unavailable</b>		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Maintenance Engineer</b>		17. KIND OF BUSINESS/INDUSTRY <b>Annunciation church</b>					
17. FATHER'S NAME (First, Middle, Last) <b>William Collins</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Ellen Cary</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Mary C. Bradley</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>14925 Pennfield Circle, Silver Spring, Md. 20906</b>					
20a. METHOD OF DISPOSITION <b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Gate of Heaven</b>		20c. LOCATION — City or Town, State <b>Silver Spring, Md.</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>DeVol Funeral Home 2222 Wisconsin Avenue, NW., Washington, DC</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Ventricular Arrhythmia</b>  Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Coronary Heart Failure</b>  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic obstructive Lung Disease</b>						24a. WAS AN AUTOPSY PERFORMED? <b>1 YES 2 NO</b>		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1 YES 2 NO</b>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1 YES 2 NO</b>		26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> OTHER: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>							
27. MANNER OF DEATH <b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</b>		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1 YES 2 NO</b>		28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) <b>1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>		29b. SIGNATURE AND TITLE OF CERTIFIER <b>Alberto Rotsztein, MD</b>				29c. LICENSE NUMBER <b>018612</b>		29d. DATE SIGNED (Month, Day, Year) <b>2-8-91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>3305 Kleisner Wood Blvd Silver Spring Md 20906</b>									
31. DATE FILED (Month, Day, Year) <b>FEB 14 '91</b>			32. REGISTRAR'S SIGNATURE 						



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05557

1. DECEDENT'S NAME (First, Middle, Last) Floyd Daniel Conrad				2. DATE OF DEATH MONTH DAY YEAR February 13, 1991		3. TIME OF DEATH 7:30 A M			
4. SOCIAL SECURITY NUMBER 220 34 5822		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 61 YRS.		7. DATE OF BIRTH (Month, Day, Year) Feb. 17, 1929		8. BIRTHPLACE (State or Foreign Country) North Carolina	
9a. FACILITY NAME (If not institution, give street and number) 5807 Vandegrift Avenue				9b. CITY, TOWN OR LOCATION OF DEATH Rockville			9c. COUNTY OF DEATH Montgomery		
10a. STATE Maryland				10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Rockville		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 5807 Vandegrift Avenue				10f. ZIP CODE 20851		10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Korea		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Manager		16b. KIND OF BUSINESS/INDUSTRY Ritz Camera Store					
17. FATHER'S NAME (First, Middle, Last) Jasper Conrad				18. MOTHER'S NAME (First, Middle, Maiden Surname) Pearl Transeau					
19a. INFORMANT'S NAME (Type/Print) Doris V. Conrad				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5807 Vandegrift Avenue, Rockville, Maryland 20851					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Parklawn Memorial Park		20c. LOCATION — City or Town, State Rockville, Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Neil E. Pines		22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory Arrest DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Metastatic Sarcoma DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death Immediate			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURED		29. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Frederick P. Smith, M.D.		29c. LICENSE NUMBER D22086		29d. DATE SIGNED (Month, Day, Year) February 13, 1991			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Frederick P. Smith, M.D. 5401 Western Avenue, N.W., Washington, D.C. 20015									
31. DATE FILED (Month, Day, Year) FEB 15 '91		32. REGISTRAR'S SIGNATURE Julia Davidson-Randall							





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 7, 213 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR


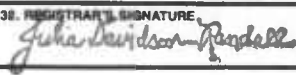
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05558

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) <b>GLENN HERBERT COX</b>				2. DATE OF DEATH MONTH <b>2</b> DAY <b>14</b> YEAR <b>91</b>		3. TIME OF DEATH <b>9:55A</b> M	
4. SOCIAL SECURITY NUMBER <b>578-26-0156</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>67</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>10/3/23</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>HOLY CROSS HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>SILVER SPRING</b>		9c. COUNTY OF DEATH <b>MONTGOMERY</b>	
10a. STATE <b>MD</b>		10b. COUNTY <b>MONTGOMERY</b>		10c. CITY, TOWN OR LOCATION <b>SILVER SPRING</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>615 HOLLYWOOD AVE.</b>				10f. ZIP CODE <b>20904</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>1/12</b> College (1-4 or 5+) <b>Clerk</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Clerk</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Wright Product</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Glenn H. Cox, Sr</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Evy Johnson</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Joseph Brooke</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>615 Hollywood Avenue Silver Spring, Md.</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Cedar Hill Cemetery</b>		20c. LOCATION — City or Town, State <b>Suitland Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Hines/Rinaldi 11800 New Hamp.Ave.S.S.Md.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Stroke</b> DUE TO (OR AS A CONSEQUENCE OF): a. <b>Stroke</b> b. <b>Metastatic Cancer</b> c. <b>Lung Cancer</b> d. <b>Cancer</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST						Approximate Interval Between Onset and Death <b>1 hr</b> <b>3 mos</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		26a. DATE OF INJURY (Month, Day, Year)		26b. TIME OF INJURY <b>M</b>		26c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
26a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		26d. DESCRIBE HOW INJURY OCCURRED		26e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Stanley A. Schwartz MD</b>				29c. LICENSE NUMBER <b>D 17368</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/14/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Stanley Schwartz 2101 Medical Park S.S.Md.</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 15 '91</b>		32. REGISTRAR'S SIGNATURE 					



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05559

1. DECEDENT'S NAME (First, Middle, Last) Henry Gordon Chapman				2. DATE OF DEATH MONTH DAY YEAR 02-20-91		3. TIME OF DEATH M			
4. SOCIAL SECURITY NUMBER 220-44-1838		5. SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>		6. AGE (In yrs. last birthday) YRS. 95		7. DATE OF BIRTH (Month, Day, Year) 10-13-95		8. BIRTHPLACE (State or Foreign Country) Ohio	
9a. FACILITY NAME (If not institution, give street and number) Meridean Nursing Center				9b. CITY, TOWN OR LOCATION OF DEATH Severna Park			9c. COUNTY OF DEATH Anne Arundel		
10a. STATE MD			10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Chevy Chase			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 3911 Blackthorn Street				10f. ZIP CODE 20815		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWI		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4 1/2				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Civil Engineer			16b. KIND OF BUSINESS/INDUSTRY Engineer		
17. FATHER'S NAME (First, Middle, Last) Eugene B. Chapman				18. MOTHER'S NAME (First, Middle, Maiden Surname) Martha Long					
19a. INFORMANT'S NAME (Type/Print) William Chapman				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 921 Rivers Edge Circle, Annapolis, MD					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Cedar Hill Cemetery			20c. LOCATION — City or Town, State Suitland, MD				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Bath J. [Signature]				22. NAME AND ADDRESS OF FACILITY Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD					
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. LUNG CARCINOMA DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 6 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER [Signature] Attending MD				29c. LICENSE NUMBER D21776		29d. DATE SIGNED (Month, Day, Year) 2/21/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) S-MUNDRA MD 1600 CRIMIN HUY #308 Glen Burnie MD 21061									
31. DATE FILED (Month, Day, Year) FEB 22 1991				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall					

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>BERKLEY F. CARROLL</b>				2. DATE OF DEATH MONTH DAY YEAR <b>FEBRUARY 18, 1991</b>		3. TIME OF DEATH M <b>6:30 P</b>	
4. SOCIAL SECURITY NUMBER <b>220-36-8057</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>50</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>11-07-40</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>THE JOHNS HOPKINS HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		9c. COUNTY OF DEATH <b>BALTIMORE CITY</b>	
10a. STATE <b>MARYLAND</b>				10b. COUNTY <b>ANNE ARUNDEL</b>		10c. CITY, TOWN OR LOCATION <b>SEVERN</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>918 SOUTH WIEKER ROAD</b>			
10f. ZIP CODE <b>21144</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>SELF EMPLOYED</b>		16b. KIND OF BUSINESS/INDUSTRY <b>GENERAL CONTRACTOR</b>			
17. FATHER'S NAME (First, Middle, Last) <b>WILLIAM CARROLL</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>GLADYS PACK</b>			
19a. INFORMANT'S NAME (Type/Print) <b>FANNIE A. CARROLL</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>918 SOUTH WIEKER RD. SEVERN, MD. 21144</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>PINELAWN MEM. PARK</b>		20c. DATE <b>2-22-1991</b>		20d. LOCATION — City or Town, State <b>ANNAPOLIS, MD.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Larry H. Reese</i>				22. NAME AND ADDRESS OF FACILITY <b>REES &amp; SONS MORTUARY, P.A.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>SEPSIS</b>							<b>1 week</b>
b. <b>NON HODGKIN LYMPHOMA</b>							<b>2 yrs</b>
c. <b>ANGIOIMMUNOBLASTIC LYMPHADENOPATHY and DISPROTEINEMIA</b>							<b>2 yrs</b>
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Elmer Huerta</i> <b>ELMER HUERTA MD. RESIDENT. INTERNAL MEDICINE</b>				29c. LICENSE NUMBER <b>H 9836</b>		29d. DATE SIGNED (Month, Day, Year) <b>02/18/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>ELMER E. HUERTA M.D. JOHNS HOPKINS HOSPITAL - 600 N. W. 1ST / Balto med 21205</b>							
31. DATE FILED (Month, Day, Year) <b>02/FEB 22 1991</b>		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



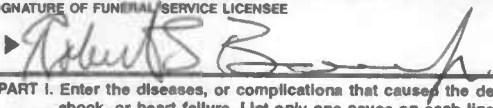

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05561

1. DECEDENT'S NAME (First, Middle, Last) <b>Thelma Ida Connelly</b>				2. DATE OF DEATH MONTH <b>02</b> DAY <b>15</b> YEAR <b>91</b>		3. TIME OF DEATH <b>3:25p</b> M			
4. SOCIAL SECURITY NUMBER <b>215-10-9097</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>77</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>08/23/13</b>		8. BIRTHPLACE (State or Foreign Country) <b>MD</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Meridian Nursing Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Severna Park</b>			9c. COUNTY OF DEATH <b>Anne Arundel</b>		
10a. STATE <b>MD</b>		10b. COUNTY <b>Anne Arundel</b>		10c. CITY, TOWN OR LOCATION <b>Severna Park</b>			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER <b>Meridian Nursing Center</b>				10f. ZIP CODE <b>21146</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>College (1-4 or 5+)</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Albert Connelly</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Wright</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Mrs. Marilyn Fowler</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2624 Marbourne Avenue Baltimore MD 21230</b>					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Loudon Park</b>		20c. LOCATION — City or Town, State <b>Baltimore, MD</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>495 Ritchie Hwy. Barranco Funeral Home Severna Park MD 21146</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Alzheimer's</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. <b>Central Vascular Accident</b> b. <b>Central Vascular Disease</b> c. d.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Central Vascular Disease</b>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <b>M. M. Mullins, MD</b>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>2/17/91</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)									
31. DATE FILED (Month, Day, Year) <b>FEB 19 1991</b>				32. REGISTRAR'S SIGNATURE 					

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				91 05562							
CERTIFICATE OF DEATH				REG. NO.											
1. DECEDENT'S NAME (First, Middle, Last) Louise H. Cook						2. DATE OF DEATH MONTH DAY YEAR 2-14-1991		3. TIME OF DEATH M							
4. SOCIAL SECURITY NUMBER 216-18-5045		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 88 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) 5-17-1902		8. BIRTHPLACE (State or Foreign Country) Maryland				
9a. FACILITY NAME (If not institution, give street and number) 109 Chesapeake Avenue						9b. CITY, TOWN OR LOCATION OF DEATH Annapolis				9c. COUNTY OF DEATH Anne Arundel					
10a. STATE Md.		10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Annapolis				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER 109 Chesapeake Avenue				10f. ZIP CODE 21403				10g. CITIZEN OF WHAT COUNTRY? USA							
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Analyst				16b. KIND OF BUSINESS/INDUSTRY State Department							
17. FATHER'S NAME (First, Middle, Last) William Franklin Harrison						18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Priscilla Sunderland									
19a. INFORMANT'S NAME (Type/Print) Margaret Miller				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 326 Locust Ave. Annapolis, Md. 21401											
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Davidsonville Meth. Cem.				20c. LOCATION — City or Town, State Davidsonville, Md.							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert S. Taylor				22. NAME AND ADDRESS OF FACILITY Taylor Funeral Chapel Annapolis, Md.											
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arrhythmia DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.										Approximate Interval Between Onset and Death					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Age, bedridden, dehydrated										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
				28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER W. M. Cook						29c. LICENSE NUMBER D24765		29d. DATE SIGNED (Month, Day, Year) 2/15/91							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) NAME - Annapolis															
31. DATE FILED (Month, Day, Year) FEB 19 1991															

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1 - FOR  
STATE  
REGISTRAR MARIA VICTORIA COOMBS  
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH  
REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Maria Victoria Coombs</i>		2. DATE OF DEATH MONTH: <i>2</i> DAY: <i>16</i> YEAR: <i>91</i>		3. TIME OF DEATH <i>11:38 P M</i>	
4. SOCIAL SECURITY NUMBER <i>577058-7722</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>96</i> YRS.	
7. DATE OF BIRTH MONTH: <i>9</i> DAY: <i>25</i> YEAR: <i>1894</i>		8. BIRTHPLACE (State or Foreign Country) <i>Maryland</i>		9. COUNTY OF DEATH <i>P. B. County</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>So. Maryland Hospital</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Chinton</i>		9c. COUNTY OF DEATH <i>P. B. County</i>	
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Prince George's</i>		10c. CITY, TOWN OR LOCATION <i>Waldorf</i>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <i>2807 Accokeek Road</i>		10f. ZIP CODE <i>20601</i>	
10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Homemaker</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Home</i>		17. FATHER'S NAME (First, Middle, Last) <i>WILLIAM COOMBS</i>	
18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>ADELLE COURTNEY</i>		19a. INFORMANT'S NAME (Type/Print) <i>Carl Coombs</i>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2807 Accokeek Rd., Waldorf, Md. 20601</i>	
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>St. Mary's Ch. Cemetery</i>		20c. LOCATION — City or Town, State <i>Piscataway, MD.</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael Blankenship</i>		22. NAME AND ADDRESS OF FACILITY <i>Hunt Funeral Home</i>		22. NAME AND ADDRESS OF FACILITY <i>P. O. Box 156, Waldorf, Md. 20604</i>	
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Arteriosclerosis cerebro-cardiovascular disease</i> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):		Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1. <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation 2. <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide 3. <input type="checkbox"/> Could not be determined	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1. <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Augusta P. Randolph MD</i>		29c. LICENSE NUMBER <i>D212-30</i>	
29d. DATE SIGNED (Month, Day, Year) <i>2-17-91</i>		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Augusta P. Randolph MD 5029 Rayburn Ct, Cap Spr Md 20748</i>		31. DATE FILED (Month, Day, Year) <i>FEB 21 '91</i>	
32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05564

1. DECEDENT'S NAME (First, Middle, Last) <i>Ruth Chester</i>				2. DATE OF DEATH MONTH <i>2</i> DAY <i>11</i> YEAR <i>91</i>		3. TIME OF DEATH M					
4. SOCIAL SECURITY NUMBER <i>220-01-9981</i>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>86</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>Feb 3 1905</i>		8. BIRTHPLACE (State or Foreign Country) <i>Md.</i>			
9a. FACILITY NAME (If not institution, give street and number) <i>Home</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Cambridge</i>			9c. COUNTY OF DEATH <i>Dorchester</i>				
RESIDENCE OF DECEDENT				10a. STATE <i>Md.</i>		10b. COUNTY <i>Dorchester</i>		10c. CITY, TOWN OR LOCATION <i>Cambridge</i>			
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER <i>603 High St.</i>		10f. ZIP CODE <i>21613</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY					
17. FATHER'S NAME (First, Middle, Last) <i>Edward Pickett</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Mary Ennells</i>							
19a. INFORMANT'S NAME (Type/Print) <i>Goldie Terry</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>603 High St. Cambridge, Md. 21613</i>							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Waukegem</i>		20c. LOCATION — City or Town, State <i>Cambridge</i>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Janelle C. Hey Buck</i>				22. NAME AND ADDRESS OF FACILITY <i>Herrn Funeral Home Cambridge Md.</i>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Sudden death</i> a. DUE TO (OR AS A CONSEQUENCE OF): <i>Atherosclerotic Cardiovascular Disease</i> b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Ruth Chester</i>		29c. LICENSE NUMBER <i>D 31018</i>		29d. DATE SIGNED (Month, Day, Year) <i>2/18/91</i>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>HE. AYUFFE 408 SPAN ST. Cambridge Md</i>											
31. DATE FILED (Month, Day, Year) <i>FEB 19 '91</i>		32. REGISTRAR'S SIGNATURE <i>John Davidson-Randell</i>									



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05565

1. DECEDENT'S NAME (First, Middle, Last) <b>Elsie M. Dow</b>				2. DATE OF DEATH MONTH <b>2</b> DAY <b>16</b> YEAR <b>91</b>		3. TIME OF DEATH <b>9:05 a.m.</b>	
4. SOCIAL SECURITY NUMBER <b>150-07-1581</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>94</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>JUNE 20, 1896</b>		8. BIRTHPLACE (State or Foreign Country) <b>NEW JERSEY</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>CIRCLE MANOR NURSING HOME</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>KENSINGTON</b>		9c. COUNTY OF DEATH <b>MONTGOMERY</b>	
10a. STATE <b>MARYLAND</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1300 S. ELWOOD AVENUE</b>				10f. ZIP CODE <b>21224</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>1</b> College (1-4 or 5+) <b>1</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOUSEWIFE</b>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>UNKNOWN</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>UNKNOWN</b>			
19a. INFORMANT'S NAME (Type/Print) <b>ELEANOR KLAU (P.R.)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5225 POOKS HILL ROAD BETHESDA, MARYLAND 20814</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>METROPOLITAN CREMATORY</b>		20c. LOCATION — City or Town, State <b>ALEXANDRIA, VIRGINIA</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Francis J. Collins</i>		22. NAME AND ADDRESS OF FACILITY <b>FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W. SIL. SPR., MD. 20901</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Alzheimer's Disease</b> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. <b>Alzheimer's Disease</b> c. <b>Alzheimer's Disease</b> d. <b>Alzheimer's Disease</b>						Approximate Interval Between Onset and Death <b>YEARS</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic Obstructive Pulmonary Disease</b>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide					
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. Bernick MD</i>					
29c. LICENSE NUMBER <b>D537</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/18/91</b>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>4115 Colie Drive, Wheaton, MD 20906</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 19 '91</b>		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rendell</i>					





91 05566

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Blanche B. Dorr				2. DATE OF DEATH MONTH DAY YEAR Feb. 16, 1991		3. TIME OF DEATH 7:55AM M	
4. SOCIAL SECURITY NUMBER 578 52 2945		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 80 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug. 7, 1910	
9a. FACILITY NAME (If not institution, give street and number) Greater Laurel Beltsville Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Laurel		9c. COUNTY OF DEATH Prince George	
10a. STATE Maryland				10b. COUNTY Prince George		10c. CITY, TOWN OR LOCATION Beltsville	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER 11948 Beltsville Drive Apt. 12				10f. ZIP CODE 20705		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 17/12 College (1-4 or 5+) Business School				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY ---	
17. FATHER'S NAME (First, Middle, Last) Aimee Boisvert				18. MOTHER'S NAME (First, Middle, Maiden Surname) Alexina Janelle			
19a. INFORMANT'S NAME (Type/Print) Lawrence G. Dorr, Sr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11948 Beltsville Dr. Beltsville, Md.			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery		20c. LOCATION — City or Town, State Silver Spring, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY Hines/Rinaldi 11800 New Hamp. Ave. S.S. Md.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>out cell carcinoma</i> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Pneumonia</i>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year) N/A		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER D24997		29d. DATE SIGNED (Month, Day, Year) 2/16/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) L. CASAS MD 8317 CITENRY LA. LAUREL MD 20707							
31. DATE FILED (Month, Day, Year) FEB 19 '91				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				91 05567					
CERTIFICATE OF DEATH				REG. NO.									
1. DECEDENT'S NAME (First, Middle, Last) MARTHA BELLE DAUBIN				2. DATE OF DEATH MONTH DAY YEAR 2/18/91				3. TIME OF DEATH A 2:00 M					
4. SOCIAL SECURITY NUMBER 577-84-5470		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 89 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) April 29, 1901		8. BIRTHPLACE (State or Foreign Country) Memphis, Tenn.	
9a. FACILITY NAME (If not institution, give street and number) CARRIAGE HILL-BETHESDA						9b. CITY, TOWN OR LOCATION OF DEATH BETHESDA				9c. COUNTY OF DEATH MONTGOMERY			
10a. STATE ---		10b. COUNTY ---		10c. CITY, TOWN OR LOCATION Washington, D.C.				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO					
10e. STREET AND NUMBER 3900 Cathedral Ave. N.W.				10f. ZIP CODE 20016				10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of life. Do NOT use retired.) Housewife		16b. KIND OF BUSINESS/INDUSTRY Own Home									
17. FATHER'S NAME (First, Middle, Last) (Unknown) Beck				18. MOTHER'S NAME (First, Middle, Maiden Surname) Martha Hamilton Montgomery									
19a. INFORMANT'S NAME (Type/Print) Mary Anne Miller				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3900 Cathedral Ave. N.W. #112A Wash. D.C. 20016									
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Mount Comfort Crematory		20c. LOCATION — City or Town, State Alex. VA.									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Michael E. Nelson				22. NAME AND ADDRESS OF FACILITY Joseph Gawler's Sons Inc. N.W. 5130 Wisconsin Ave. Wash. D.C. 20016									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cerebral Vascular Disease  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. Osteoporosis, Vertebral Fractures b. Weight Loss, Gastritis c. d.								Approximate Interval Between Onset and Death months years many months					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER David R. Lawrence				29c. LICENSE NUMBER 3347		29d. DATE SIGNED (Month, Day, Year) Feb. 20, 1991			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) David R. Lawrenz MD. 1145 19th Street N.W. 20036													
31. DATE FILED (Month, Day, Year) FEB 20 '91				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall									



91 05568

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Elizabeth W. Davis</b>		2. DATE OF DEATH MONTH DAY YEAR <b>February 13, 1991</b>		3. TIME OF DEATH <b>10:30 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>214-01-1109</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>74</b> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <b>Feb. 10, 1917</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>13122 Pickering Drive</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Germantown</b>		9c. COUNTY OF DEATH <b>Montgomery</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Germantown</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>13122 Pickering Drive</b>		10f. ZIP CODE <b>20874</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (13-16 or 5+)	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Payroll Clerk</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Department of Transportation U.S. Government</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Harry M. Webb</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Helen Henderson</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Eileen D. Carzon</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8223 Londonderry Court Laurel, Maryland 20707</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>National Memorial Park</b>		20c. LOCATION — City or Town, State <b>Falls Church, Virginia</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Will E. Bauer Jr.</b> M00672		22. NAME AND ADDRESS OF FACILITY <b>Robert A. Pumphrey Funeral Home/Rockville, Inc., 300 West Montgomery Avenue, Rockville, Maryland 20850-2805</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardio pulmonary Arrest</b>  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  b. <b>Atherosclerotic Cardiovascular disease</b>  c.  d.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic obstructive pulmonary disease</b>					Approximate Interval Between Onset and Death
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Daniel A. Jaller</b>		29c. LICENSE NUMBER <b>D33138</b>		29d. DATE SIGNED (Month, Day, Year) <b>February 13, 1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Daniel A. Jaller, M.D., 19511 Doctors Drive, Germantown, Maryland 20874</b>					
31. DATE FILED (Month, Day, Year) <b>FEB 19 '91</b>		32. REGISTRAR'S SIGNATURE <b>Juha Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

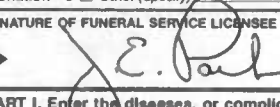
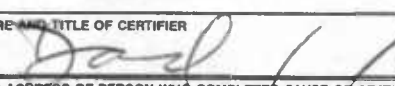
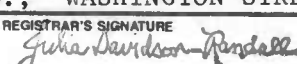


TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05569

1. DECEDENT'S NAME (First, Middle, Last) JOHN VINCENT DelVECCHIO				2. DATE OF DEATH MONTH DAY YEAR FEB. 11, 1991		3. TIME OF DEATH 3:00 PM			
4. SOCIAL SECURITY NUMBER 577-03-3034		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 82 YRS.		7. DATE OF BIRTH (Month, Day, Year) OCT. 26, 1908		8. BIRTHPLACE (State or Foreign Country) NEW YORK	
9a. FACILITY NAME (If not institution, give street and number) 263 SHOREVIEW DRIVE				9b. CITY, TOWN OR LOCATION OF DEATH MECHANICSVILLE			9c. COUNTY OF DEATH ST. MARY'S		
10a. STATE MARYLAND			10b. COUNTY ST. MARY'S		10c. CITY, TOWN OR LOCATION MECHANICSVILLE			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 263 SHOREVIEW DRIVE				10f. ZIP CODE 20659		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4		16a. RESTAURANT OWNER (Give kind of work done during most of working life. Do NOT use retired.) SELF EMPLOYED BUILDING DEVELOPER		16b. KIND OF BUSINESS/INDUSTRY RESTAURANT --- CONSTRUCTION/DEVELOPMENT					
17. FATHER'S NAME (First, Middle, Last) JOHN VINCENT DelVECCHIO				18. MOTHER'S NAME (First, Middle, Maiden Surname) AMELIA VALENTE					
19a. INFORMANT'S NAME (Type/Print) Betty B. DelVecchio				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as #10					
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory		20c. LOCATION — City or Town, State Alexandria, Virginia					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  M00896				22. NAME AND ADDRESS OF FACILITY DeVol Funeral Home 10 E. Deer Park Dr. - Gaithersburg, MD 20877					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Alzheimers Disease</u> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST						Approximate Interval Between Onset and Death years			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED		29. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER D25230		29d. DATE SIGNED (Month, Day, Year) 2/12/91			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DAVID C. ALLEN, M.D., WASHINGTON STREET, LEONARDTOWN, MARYLAND 20650									
31. DATE FILED (Month, Day, Year) FEB 14 '91		32. REGISTRAR'S SIGNATURE 							





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05570

1. DECEDENT'S NAME (First, Middle, Last) Edith S. Dunn				2. DATE OF DEATH MONTH DAY YEAR 02 06 91		3. TIME OF DEATH 12:05 3 M				
4. SOCIAL SECURITY NUMBER 231 70 5410		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 92 YRS.		7. DATE OF BIRTH (Month, Day, Year) 11-06-1898		8. BIRTHPLACE (State or Foreign Country) New York		
9a. FACILITY NAME (If not institution, give street and number) Sacred Heart Home, Inc.				9b. CITY, TOWN OR LOCATION OF DEATH Hyattsville			9c. COUNTY OF DEATH Prince George's			
10a. STATE Maryland			10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION Hyattsville			10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		
10e. STREET AND NUMBER 5105 Queens Chapel Road				10f. ZIP CODE 20782			10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: Caucasian			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (14 or 8+) 2			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker			16b. KIND OF BUSINESS/INDUSTRY None				
17. FATHER'S NAME (First, Middle, Last) Victor Shanley				18. MOTHER'S NAME (First, Middle, Maiden Surname) Edith Therry						
19a. INFORMANT'S NAME (Type/Print) Ray A Dunn, Jr				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P O Box 22 Roseland, Virginia 22967						
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) The National Cemetery			20c. LOCATION — City or Town, State Arlington, Virginia					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald F. Rowles				22. NAME AND ADDRESS OF FACILITY Demaine Funeral Homes, Inc Alexandria, Virginia 22314						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Senile Dementia Alzheimer's Type</u> DU TO (OR AS A CONSEQUENCE OF): b. <u>ASLD</u> DU TO (OR AS A CONSEQUENCE OF): c. <u>URSA</u> DU TO (OR AS A CONSEQUENCE OF): d. <u>Anemia</u> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death 1983 1982 1982 1982			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA			OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) N/A		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		
28e. PLACE OF INJURY — A1 home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER DGP atuh JIM				29c. LICENSE NUMBER D 07729		29d. DATE SIGNED (Month, Day, Year) 2/6/91				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) B B Patrick MD 4551 Colesville Rd SS, Md 20910										
31. DATE FILED (Month, Day, Year) FEB 14 '91				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall						



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.




1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05571

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) ELIZABETH V. DOLAN				2. DATE OF DEATH MONTH DAY YEAR February 13, 1991		3. TIME OF DEATH 6:40 P M				
4. SOCIAL SECURITY NUMBER 050-10-9403		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 80 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 19, 1910		8. BIRTHPLACE (State or Foreign Country) Scotland		
9a. FACILITY NAME (If not institution, give street and number) Brooke Grove Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Olney			9c. COUNTY OF DEATH Montgomery			
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Poolesville			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 17521 Collier Circle				10f. ZIP CODE 20837		10g. CITIZEN OF WHAT COUNTRY? United States				
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16. KIND OF BUSINESS/INDUSTRY Own Home						
17. FATHER'S NAME (First, Middle, Last) (Unknown First) McGinley				18. MOTHER'S NAME (First, Middle, Maiden Surname) Nellie Peddie						
19a. INFORMANT'S NAME (Type/Print) Michelle Stolzenburg				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as #10						
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Calverton National Cemetery			20c. LOCATION — City or Town, State Calverton, New York					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  MO0827		22. NAME AND ADDRESS OF FACILITY R.J. O'Shea Funeral Home 94 East Montauk Hwy, Hampton Bays, NY 11946								
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Sepsis</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>Bronchopneumonia</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>Fractured Hip</u> DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 1-3-91		28b. TIME OF INJURY — M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED Fall.		
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) Brooke Grove Nursing Home		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) Olney Maryland								
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER  M.D.				29c. LICENSE NUMBER 208546		29d. DATE SIGNED (Month, Day, Year) Feb 14, 1991				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John F. Tauber, M.D. 8218 Wisconsin Ave, #414 Bethesda, MD 20814										
31. DATE FILED (Month, Day, Year) FEB 15 '91		32. REGISTRAR'S SIGNATURE 								



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

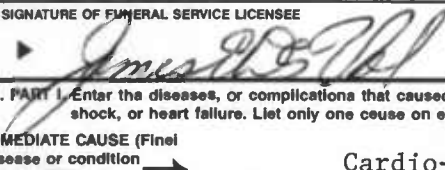
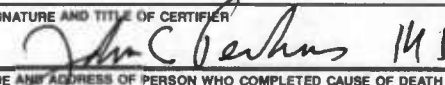
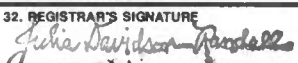
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05572

1. DECEDENT'S NAME (First, Middle, Last) <b>John L. Doyle</b>				2. DATE OF DEATH MONTH DAY YEAR <b>February 11, 1991</b>				3. TIME OF DEATH M <b>M</b>			
4. SOCIAL SECURITY NUMBER <b>578-09-8238</b>		5. SEX <b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>68</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>May 31, 1922</b>		8. BIRTHPLACE (State or Foreign Country) <b>Washington, D.C.</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Shady Grove Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Gaithersburg</b>				9c. COUNTY OF DEATH <b>Montgomery</b>			
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Rockville</b>				10d. INSIDE CITY LIMITS? <b>1</b> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER <b>622 Lincoln Street</b>				10f. ZIP CODE <b>20854</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>College (1-4 or 5+)</b> <b>2</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Correctional Officer</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Federal Bureau of Prisons</b>			
17. FATHER'S NAME (First, Middle, Last) <b>William Doyle</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Agnes Jordan</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Margaret D. Giebel</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9503 Singleton Drive Bethesda, Maryland 20817</b>							
20a. METHOD OF DISPOSITION <b>1</b> <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Gate of Heaven Cemetery</b>				20c. LOCATION — City or Town, State <b>Silver Spring, Maryland</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>DeVol Funeral Home</b> <b>2222 Wisconsin Avenue, N.W. Washington, DC 20007</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>Cardio-Pulmonary Arrest</b> <b>DUE TO (OR AS A CONSEQUENCE OF):</b> <b>Atherosclerosis</b> <b>Hypertension</b> <b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> <b>Diabetes Mellitus</b> <b>Hyperlipemim</b>								Approximate Interval Between Onset and Death <b>20 min.</b> <b>10 years</b> <b>1973</b>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes Mellitus</b> <b>Hyperlipemim</b>								24a. WAS AN AUTOPSY PERFORMED? <b>1</b> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1</b> <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) <b>HOSPITAL:</b> <b>2</b> <input checked="" type="checkbox"/> Inpatient <b>2</b> <input checked="" type="checkbox"/> Outpatient <b>3</b> <input type="checkbox"/> DOA <b>OTHER:</b> <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation <b>2</b> <input type="checkbox"/> Accident <b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide <b>6</b> <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
				28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER  <b>John C. Perkins MD</b>								29c. LICENSE NUMBER <b>DO 9991</b>		29d. DATE SIGNED (Month, Day, Year) <b>Feb. 11, 1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>JOHN C. PERKINS, MD</b> <b>5401 Western Ave., N.W., Washington, D.C. 20015</b>											
31. DATE FILED (Month, Day, Year) <b>FEB 19 '91</b>				32. REGISTRAR'S SIGNATURE 							



91 05573

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <i>William C. Dean</i>				2. DATE OF DEATH MONTH <i>2</i> DAY <i>16</i> YEAR <i>91</i>		3. TIME OF DEATH <i>4:47 P.M.</i>	
4. SOCIAL SECURITY NUMBER <i>437-26-8196A</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>77</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>10-27-13</i>	
8. BIRTHPLACE (State or Foreign Country) <i>Arkansas</i>				9a. FACILITY NAME (If not institution, give street and number) <i>Chesapeake Manor Nursing Home</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Arnold</i>	
9c. COUNTY OF DEATH <i>Anne Arundel</i>				10a. STATE <i>MD</i>		10b. COUNTY <i>Anne Arundel</i>	
10c. CITY, TOWN OR LOCATION <i>1115 Skyway Drive, Annapolis</i>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <i>1115 Skyway Drive</i>	
10f. ZIP CODE <i>21401</i>				10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>2</i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Steamfitter</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Welding</i>	
17. FATHER'S NAME (First, Middle, Last) <i>Frank Levi Dean</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Gertrude Mae Shepherd</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Mary C. Dean</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1115 Skyway Drive, Annapolis, MD 21401</i>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Metro Crematory</i>		20c. LOCATION — City or Town, State <i>Baltimore, MD</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Pat A. Smith</i>				22. NAME AND ADDRESS OF FACILITY <i>Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Respiratory Failure</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Chronic Obstructive Pulmonary Disease</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>Status Post Pneumoniae</i> DUE TO (OR AS A CONSEQUENCE OF): d. Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Alzheimer's Disease</i>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>William C. Dean Medical Director</i>				29c. LICENSE NUMBER <i>D21684</i>		29d. DATE SIGNED (Month, Day, Year) <i>2/18/91</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>C.V. CYRIAC MD 1600 CRAIN HWY, GREENBURN, MD 21061</i>							
31. DATE FILED (Month, Day, Year) <i>FEB 20 1991</i>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





91 05574

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ETHEL G DORMAN</b>				2. DATE OF DEATH MONTH <b>2</b> DAY <b>20</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>0406</b> M	
4. SOCIAL SECURITY NUMBER <b>216-38-0302</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>82</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>8-16-1908</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Washington County Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Hagerstown</b>	
9c. COUNTY OF DEATH <b>Washington</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Washington</b>	
10c. CITY, TOWN OR LOCATION <b>Boonsboro</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>20041 Millpoint Road</b>	
10f. ZIP CODE <b>21713</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>6 yrs.</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Residence</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Hubert E. Reeder</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Alice R. Hutzell</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Olive J. Alder</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8513 Boonsboro Pike Boonsboro, Maryland 21713</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Benevola Cemetery</b>		20c. LOCATION — City or Town, State <b>Benevola, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Douglas A. Fiery</b>				22. NAME AND ADDRESS OF FACILITY <b>Bast Funeral Home Boonsboro, Maryland</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiac arrhythmia (Bradycardia)</b>							
Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>- recently operated colon cancer</b> <b>- severe ASCVD</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Dr. R. Guedenet</b>				29c. LICENSE NUMBER <b>D32518</b>		29d. DATE SIGNED (Month, Day, Year) <b>2-20-91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. R. Guedenet M.D. 100 Geeting Lane Keedysville, Maryland 21756</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 21 '91</b>				32. REGISTRAR'S SIGNATURE <b>Gina Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 05575

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Cora Lee Douglas</b>				2. DATE OF DEATH MONTH <b>2</b> DAY <b>18</b> YEAR <b>91</b>		3. TIME OF DEATH <b>1920 P M</b>	
4. SOCIAL SECURITY NUMBER <b>234-66-8295</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>78</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>7-16-1912</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Virginia</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Washington County Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Hagerstown</b>	
9c. COUNTY OF DEATH <b>Washington</b>				10a. STATE <b>Maryland</b>			
10b. COUNTY <b>Washington</b>				10c. CITY, TOWN OR LOCATION <b>Boonsboro</b>			
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>Reeders Memorial Home</b>			
10f. ZIP CODE <b>21713</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>8</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Laborer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Cannery</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Harvey H.. Craun</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Annie Norfolk</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Emma Lee Jones</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1522 Brown Rd. Knoxville, Md. 21758</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Middleway Masonic Cemetery</b>		20c. LOCATION — City or Town, State <b>Inwood, W.VA.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Charles C. Buerer #100068</b>				22. NAME AND ADDRESS OF FACILITY <b>Burner Trade Services</b> <b>1037 Dual Place, Hag. Md. 21740</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acute Pulmonary embolism and pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF):  Approximate Interval Between Onset and Death							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Alzheimer's type Dementia</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>R.L. Kuyler MD</b>				29c. LICENSE NUMBER <b>D26579</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/19/91 2000</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>R.L. Kuyler 100 Geeting Lane Kneegrove, md 21756</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 20 91</b>				32. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.







91 05577

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) EVELYN E DIGGS				2. DATE OF DEATH MONTH DAY YEAR 02 12 91		3. TIME OF DEATH 2:05 PM M	
4. SOCIAL SECURITY NUMBER 215-34-5263		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (in yrs. last birthday) 69 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jan 10 1922	
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9a. FACILITY NAME (If not institution, give street and number) NORTH ARUNDEL HOSPITAL ASSOCIATION		9b. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE	
9c. COUNTY OF DEATH A.A. COUNTY				10a. STATE MARYLAND		10b. COUNTY ANNE ARUNDEL	
10c. CITY, TOWN OR LOCATION CROWNSVILLE				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER P.O. BOX 680	
10f. ZIP CODE 21032				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) GRANDERSON EDWARDS				16. MOTHER'S NAME (First, Middle, Maiden Surname) ELEANOR PINDELL			
19a. INFORMANT'S NAME (Type/Print) WILLIAM H. DIGGS				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. BOX 680 CROWNSVILLE, MD. 21032			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) METRO CREMATORY		20c. LOCATION — City or Town, State DATE 2-16-91 BALTIMORE, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Larry H. Reese				22. NAME AND ADDRESS OF FACILITY 821 WEST ST. ANNAPOLIS, MD. 21401 REESE & SONS MORTUARY, P.A.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Pancreatic carcinoma</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate interval between Onset and Death 5 months						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER M.D.				29c. LICENSE NUMBER D20431		29d. DATE SIGNED (Month, Day, Year) 2-12-91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) LONG S HSU M.D./300 HOSPITAL DRIVE SUITE 230/GLEN BURNIE, MARYLAND 21061							
31. DATE FILED (Month, Day, Year) FEB 19 1991				32. REGISTRAR'S SIGNATURE John Davidson-Rendell			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3, 4, and 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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REVISED

10/17/77

RECEIVED



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05578

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) <b>Darien B. Daughtrey</b>				2. DATE OF DEATH MONTH DAY YEAR <b>2-17-1991</b>		3. TIME OF DEATH HOUR MIN. <b>6 20 A</b>					
4. SOCIAL SECURITY NUMBER <b>577-12-0335</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>86</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>12-8-1904</b>		8. BIRTHPLACE (State or Foreign Country) <b>Virginia</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Pleasant Living Convalescent Ctr.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Edgewater</b>				9c. COUNTY OF DEATH <b>Anne Arundel</b>			
10a. STATE <b>Md.</b>		10b. COUNTY <b>Anne Arundel</b>		10c. CITY, TOWN OR LOCATION <b>Edgewater</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER <b>3674 Bay Drive</b>				10f. ZIP CODE <b>21037</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WWII</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5+</b>		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Dentist</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Dentistry</b>							
17. FATHER'S NAME (First, Middle, Last) <b>Albert Daughtrey</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Maude Butler</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Eva Daughtrey</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3674 Bay Drive Edgewater, Md. 21037</b>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Lakemont Cemetery</b>		20c. LOCATION — City or Town, State <b>Davidsonville, Md.</b>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert S. Taylor</i>				22. NAME AND ADDRESS OF FACILITY <b>Taylor Funeral Chapel Annapolis, Md.</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>MI</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>COPD</b> <b>Normal Pressure Hypertension</b>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>D23557</b>		29d. DATE SIGNED (Month, Day, Year) <b>2-18-91</b>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>ANTHONY M. CAPUTO 132 HOLIDAY CT #201 ANNAPOLIS MD 21401</b>											
31. DATE FILED (Month, Day, Year) <b>FEB 19 1991</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>							



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05579

1. DECEASED'S NAME (First, Middle, Last) <b>LESTER DOLLY</b>				2. DATE OF DEATH MONTH <b>FEBRUARY</b> DAY <b>17</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>2:14 P.</b>			
4. SOCIAL SECURITY NUMBER <b>234-40-3571</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>92</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>02-08-1899</b>		8. BIRTHPLACE (State or Foreign Country) <b>WV</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Memorial Hospital &amp; Medical Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Cumberland</b>			9c. COUNTY OF DEATH <b>Allegany</b>		
10a. STATE <b>WV</b>		10b. COUNTY <b>Allegany</b>		10c. CITY, TOWN OR LOCATION <b>Short Gap,</b>			10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
10e. STREET AND NUMBER <b>Route 2 Box 442</b>				10f. ZIP CODE <b>26753</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>		
15. DECEASED'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>12</b>				16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>ret. construction worker</b>			16b. KIND OF BUSINESS/INDUSTRY <b>construction</b>		
17. FATHER'S NAME (First, Middle, Last) <b>Alfred Dolly</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Melissa Mallow</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Mrs. Mildred M. Davis</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Oldtown, MD 21555</b>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name) <b>Oldtown Cemetery</b>			DATE		20c. LOCATION — City or Town, State <b>Oldtown, MD</b>		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>James F. Scarpelli</b>				22. NAME AND ADDRESS OF FACILITY <b>Scarpelli Funeral Home Cumberland, MD 21502</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiovascular Arrest</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { a. <b>Myocardial Infarction</b> b. <b>MI</b> c. <b>CAI</b> d. <b>ASCVD</b>  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Advanced age</b>								Approximate Interval Between Onset and Death	
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <b>William W.</b>				29c. LICENSE NUMBER <b>D16041</b>		29d. DATE SIGNED (Month, Day, Year) <b>2-17-91</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Terry Williams Memorial Hospital Medical Building Cumberland, MD 21502</b>									
31. DATE FILED (Month, Day, Year) <b>FEB 19 1991</b>				32. REGISTRAR'S SIGNATURE <b>John Davidson-Rendell</b>					

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91 05580

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ALLAN EAFFY</b>				2. DATE OF DEATH MONTH <b>2</b> DAY <b>15</b> YEAR <b>91</b>		3. TIME OF DEATH <b>2:40 PM</b>	
4. SOCIAL SECURITY NUMBER <b>210-05-5497</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>79</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Dec. 24, 1911</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Cleveland, Ohio</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Suburban Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Bethesda Maryland</b>	
9c. COUNTY OF DEATH <b>Montgo.</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>	
10c. CITY, TOWN OR LOCATION <b>Chevy Chase</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>4601 N. Park Ave.</b>	
10f. ZIP CODE <b>20815</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Engineer</b>				16b. KIND OF BUSINESS/INDUSTRY <b>U.S. Government</b>			
17. FATHER'S NAME (First, Middle, Last) <b>David Eaffy</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Emma Lightman</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Betty Eaffy</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4601 N. Park Ave. Chevy Chase, Maryland 20815</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Mount Comfort Crematory</b>			
20c. LOCATION — City or Town, State <b>Alex. VA.</b>				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Vernon [Signature]</b>			
22. NAME AND ADDRESS OF FACILITY <b>Joseph Gawler's Sons Inc. N.W. 5130 Wisconsin Ave. Wash. D.C. 20016</b>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Intracerebral hemorrhage -</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  <b>Subdural hematoma metastatic plasmatic carcinoma</b>			
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) <b>2/15/91</b>			
28b. TIME OF INJURY <b>M</b>				28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Horace W. Bernton</b>				29c. LICENSE NUMBER <b>D-000534</b>			
29d. DATE SIGNED (Month, Day, Year) <b>2/15/91</b>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (JETER 27) (Type, Print) <b>Horace W. Bernton 4743 Bradley Blvd. Chevy Chase, Maryland 20815</b>			
31. DATE FILED (Month, Day, Year) <b>FEB 19 '91</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05581

1. DECEDENT'S NAME (First, Middle, Last) <b>CHRISTINE E. ERB</b>				2. DATE OF DEATH MONTH DAY YEAR <b>02 - 18 - 91</b>		3. TIME OF DEATH <b>10 45 P M</b>	
4. SOCIAL SECURITY NUMBER <b>577-30-5423</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>92</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>02-11-99</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Ocala, FL</b>		9a. FACILITY NAME (If not institution, give street and number) <b>Pleasant Living Nursing Ctr.</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Edgewater</b>		9c. COUNTY OF DEATH <b>Anne Arundel</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MD</b>		10b. COUNTY <b>Anne Arundel</b>		10c. CITY, TOWN OR LOCATION <b>Edgewater</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>144 Washington Road</b>				10f. ZIP CODE <b>21037</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>Secretary</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Secretary</b>		16b. KIND OF BUSINESS/INDUSTRY <b>U.S. Government</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Charles Hannah</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Blanche Yonce</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Derrill Pratt Jr.</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1 Clacton La. Belle Vista, AR 72714</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metro Crematory</b>		20c. LOCATION — City or Town, State <b>Baltimore, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Beth J. Adell</b>				22. NAME AND ADDRESS OF FACILITY <b>Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Respiratory Failure</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <b>Pneumonia</b> c. <b>Chronic Aspiration</b> d. <b>Organic Brain Syndrome</b>						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Dr. Claman</b>				29c. LICENSE NUMBER <b>D08314</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/19/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>George C. Samaras and 205 Ridgely Ave Annapolis</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 20 1991</b>				32. REGISTRAR'S SIGNATURE <b>Johanna Davidson-Randall</b>			

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

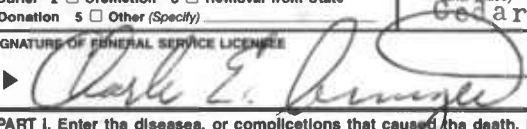
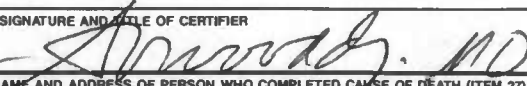

1 - FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				REG. NO.															
1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH				3. TIME OF DEATH															
James L. Evans				2-20-91				2:15 A M															
4. SOCIAL SECURITY NUMBER		5. SEX		6. AGE (In yrs. last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		7. DATE OF BIRTH		8. BIRTHPLACE (State or Foreign Country)											
220-16-7842		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		63 YRS.		MONTHS DAYS		HOURS MIN.		8-1-27													
9a. FACILITY NAME (If not institution, give street and number)				9b. CITY, TOWN OR LOCATION OF DEATH				9c. COUNTY OF DEATH															
Anne Arundel Medical Center				Annapolis				Anne Arundel															
10a. STATE		10b. COUNTY		10c. CITY, TOWN OR LOCATION		10d. INSIDE CITY LIMITS?		10e. STREET AND NUMBER				10f. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?									
MD		Anne Arundel		Annapolis		<input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		1709 Cedar Park Road				21401		USA									
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES?		13. WAS DECEDENT OF HISPANIC ORIGIN?		14. RACE - American Indian, Black, White, etc.		15. DECEDENT'S EDUCATION						16a. DECEDENT'S USUAL OCCUPATION		16b. KIND OF BUSINESS/INDUSTRY							
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		Specify:		Elementary/Secondary (0-12) College (1-4 or 5+) 12 4+						Sales Manager		Furniture							
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)				19. INFORMANT'S NAME (Type/Print)						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)									
James Elmer Evans				Virginia Lacey				Joyce E. Evans						1709 Cedar Park Road, Annapolis, MD 21401									
20a. METHOD OF DISPOSITION				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)				20c. LOCATION - City or Town, State				21. SIGNATURE OF FUNERAL SERVICE LICENSEE						22. NAME AND ADDRESS OF FACILITY					
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				Metro Crematory				Baltimore, MD										Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death											
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Lung Cancer												15 mos											
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF):																							
c. DUE TO (OR AS A CONSEQUENCE OF):																							
d. DUE TO (OR AS A CONSEQUENCE OF):																							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED?				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?							
												1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER?				26. PLACE OF DEATH (Check only one)																			
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA				OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)															
27. MANNER OF DEATH				28a. DATE OF INJURY		28b. TIME OF INJURY		28c. INJURY AT WORK?		28d. DESCRIBE HOW INJURY OCCURRED													
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				(Month, Day, Year)		M		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO															
				28e. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)															
29a. CERTIFIER (Check only one)												29b. LICENSE NUMBER				29c. DATE SIGNED (Month, Day, Year)							
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												D5192				2/20/91							
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)																							
R. E. Hochman, MD - 16 Murray Ave, Annapolis, MD 21401																							
31. DATE FILED (Month, Day, Year)				32. REGISTRAR'S SIGNATURE																			
FEB 21 1991																							



91 05583

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>CARROLL PAUL ECKSTEIN</b>				2. DATE OF DEATH MONTH <b>02</b> DAY <b>17</b> YEAR <b>91</b>		3. TIME OF DEATH <b>12:40 P M</b>	
4. SOCIAL SECURITY NUMBER <b>197-10-9916</b>		5. SEX <b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>85</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>08-17-05</b>	
8. BIRTHPLACE (State or Foreign Country) <b>KENTUCKY</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Physicians Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>La Plata</b>	
9c. COUNTY OF DEATH <b>Charles</b>				RESIDENCE OF DECEDENT			
10a. STATE <b>Md.</b>		10b. COUNTY <b>Anne Arundel</b>		10c. CITY, TOWN OR LOCATION <b>Annapolis</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>12 Dunbarton Court</b>				10f. ZIP CODE <b>21403</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <b>3</b> <input checked="" type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>10</b> Elementary/Secondary (0-12) <b>College (1-4 or 5+)</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Machinist</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Civil Service</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Charles Nickolas Eckstein</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Claire Newell</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Donald E. Eckstein</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1101 Cornell Ct. Waldorf, Md. 20601</b>			
20a. METHOD OF DISPOSITION <b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State <b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Gar Hill Cemetery</b>		20c. LOCATION — City or Town, State <b>Suitland, Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Taylor Funeral Chapel Annapolis, Md.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>Sudden death, Myocardial infarction</b> DUE TO (OR AS A CONSEQUENCE OF):					Approximate Interval Between Onset and Death <b>0</b>
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. <b>Arteriosclerotic Cardiovascular disease</b> DUE TO (OR AS A CONSEQUENCE OF):					<b>10yrs</b>
		c. _____ DUE TO (OR AS A CONSEQUENCE OF):					
		d. _____ DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA OTHER: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input checked="" type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation <b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined <b>3</b> <input type="checkbox"/> Suicide <b>7</b> <input type="checkbox"/> Homicide <b>4</b> <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <b>1</b> <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D11176</b>		29d. DATE SIGNED (Month, Day, Year) <b>02.17.91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>A.O. WOODDY, M.D. Box 430 100 Cressk Ave, LA PLATA, MD. 20646</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 19 1991</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Benjamin</b>		2. DATE OF DEATH MONTH <b>1</b> DAY <b>26</b> YEAR <b>91</b>		3. TIME OF DEATH <b>11:55 P M</b>
4. SOCIAL SECURITY NUMBER <b>577-94-0236</b>	5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>20</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>3/4/70</b>	8. BIRTHPLACE (State or Foreign Country) <b>Virginia</b>
9a. FACILITY NAME (If not institution, give street and number) <b>Billings Ave &amp; Clark St.</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Capitol Hgts,</b>		9c. COUNTY OF DEATH <b>Prince George's</b>
RESIDENCE OF DECEDENT				
10a. STATE <b>Md.</b>	10b. COUNTY <b>P.G.</b>	10c. CITY, TOWN OR LOCATION <b>Capitol Heights</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
10e. STREET AND NUMBER <b>3805 Ellis Street</b>		10f. ZIP CODE <b>20743</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9th grade</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Construction Worker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Construction</b>
17. FATHER'S NAME (First, Middle, Last) <b>Benjamin Evans</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Rebecca Farmer</b>		
19a. INFORMANT'S NAME (Type/Print) <b>Rebecca Pritchett</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3805 Ellis Street Capitol Heights, Md 20743</b>		
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>HARMONY MEMORIAL FEB 1 91 LANDOVER, MARYLAND</b>		20c. LOCATION — City or Town, State
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>W.H. Bacon (276)</b>		22. NAME AND ADDRESS OF FACILITY <b>W.H. Bacon Funeral Home 3447 14th Street, N.W. Wash. DC</b>		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Gunshot wounds of head</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.				Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>street</b>		
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Sudden 7 <input type="checkbox"/> Could not be determined 4 <input checked="" type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>1/26/91</b>	28b. TIME OF INJURY <b>10:20P M</b>	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
		28d. DESCRIBE HOW INJURY OCCURRED <b>Subject shot</b>		
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>street</b>		
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>Billings Ave &amp; Clark St., Capitol Hgts.</b>		
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Donald E. Wright For</b>		29c. LICENSE NUMBER <b>OCME</b>	29d. DATE SIGNED (Month, Day, Year) <b>1/27/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Frank J. Peretti, M.D. - Assistant 111 Penn St. Balto., MD. ss</b>				
31. DATE FILED (Month, Day, Year) <b>FEB 28 1991</b>		32. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 05585

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>RAY M. Firestone</b>				2. DATE OF DEATH MONTH <b>2</b> DAY <b>18</b> YEAR <b>91</b>		3. TIME OF DEATH <b>4:10 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>577-48-2707</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>92</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>2/6/1899</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Connecticut</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Suburban Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Bethesda</b>	
9c. COUNTY OF DEATH <b>Montgomery</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>	
10c. CITY, TOWN OR LOCATION <b>Chevy Chase</b>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>4701 Willard Avenue, #719</b>	
10f. ZIP CODE <b>20815</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Retail Owner</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Ladies Apparel</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Barnet Shapiro</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Anna Garfinkle</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Ross Firestone (son)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>539 West 112th Street, New York, NY 10025</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Adas Israel Congregation</b>		20c. LOCATION — City or Town, State <b>2/19 Washington, D.C.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike, Rockville, MD 20852</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acute Myocardial Infarction</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
b. <b>Coronary Artery Disease</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
c. <b>Arteriosclerosis</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
d. <b>Diabetes Mellitus</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Mixed Connective Tissue Disease</b> <b>Aortic Valve Disease</b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <b>1</b> <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>D13818</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/18/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>5530 Wisconsin Ave Chevy Chase, MD 20817</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 20 '91</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





91 05586

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>LINNIE ODELLA FLETCHER</b>				2. DATE OF DEATH MONTH <b>02</b> DAY <b>13</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>13:38</b> M	
4. SOCIAL SECURITY NUMBER <b>216-22-6457</b>		5. SEX 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>84</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>04-17-1906</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Garrett Memorial Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Oakland</b>		9c. COUNTY OF DEATH <b>Garrett</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MD</b>		10b. COUNTY <b>Allegany</b>		10c. CITY, TOWN OR LOCATION <b>Cumberland,</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>438 Goethe Street</b>				10f. ZIP CODE <b>21502</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>housewife</b>		16b. KIND OF BUSINESS/INDUSTRY <b>own home</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Henry Barnes</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Irene Leasure</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mr. Melvin Fletcher, Sr.</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>708 Webb Street Aberdeen, MD 21001</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Mt. Hope Cemetery</b>		20c. LOCATION — City or Town, State <b>Artemas, PA</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>James F. Scarpelli</b>				22. NAME AND ADDRESS OF FACILITY <b>Scarpelli Funeral Home Cumberland, MD 21502</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. <b>acute bilateral bacterial pneumonia</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
b. <b>severe thoracic kyphosis</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
c. <b>compression fractures of thoracic vertrebral bodies</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
d. <b>osteoporosis</b>							
Approximate Interval Between Onset and Death							
3 days							
13 years							
13 years							
30 years							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>organic brain syndrome</b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
26. PLACE OF DEATH (Check only one)							
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH							
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide							
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Walter K. Naumann M.D.</b>				29c. LICENSE NUMBER <b>D25759</b>		29d. DATE SIGNED (Month, Day, Year) <b>Feb 13, 1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Walter K. Naumann, M.D. Accident MD 21520</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 14 1991</b>				32. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>			

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



91 05587

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) John W. Franks				2. DATE OF DEATH MONTH 2-18 DAY 1991 YEAR 91		3. TIME OF DEATH 3:05 PM					
4. SOCIAL SECURITY NUMBER 208-16-3796		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 65 YRS.		7. DATE OF BIRTH (Month, Day, Year) 3/16/25		8. BIRTHPLACE (State or Foreign Country) Penn.			
9a. FACILITY NAME (If not institution, give street and number) Anne Arundel Medical Center				9b. CITY, TOWN OR LOCATION OF DEATH Annapolis				9c. COUNTY OF DEATH Anne Arundel			
10a. STATE Md.		10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Annapolis				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER 570 Bellerive Dr. Apt. 233				10f. ZIP CODE 21401		10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Salesman		16b. KIND OF BUSINESS/INDUSTRY Furniture					
17. FATHER'S NAME (First, Middle, Last) John B. Franks				18. MOTHER'S NAME (First, Middle, Maiden Surname) Olive Metheny							
19a. INFORMANT'S NAME (Type/Print) Sylvia Franks				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 570 Bellerive Dr. Annapolis, Md.							
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory Baltimore, Md.				20c. LOCATION — City or Town, State Baltimore, Md.					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶				22. NAME AND ADDRESS OF FACILITY 3111 Mountain Rd. Stallings Funeral Home Pasadena, Md. 21122							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Intracerebral Hemorrhage DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide 4 <input type="checkbox"/>		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER John W. Franks MD				29c. LICENSE NUMBER D18529		29d. DATE SIGNED (Month, Day, Year) 2-19-91					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/print) 600 RIDGEWAY AVE Annapolis, Md 21401											
31. DATE FILED (Month, Day, Year) FEB 22 1991											

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. Page 6 may be retained by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				91 05588											
1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH				3. TIME OF DEATH											
JOHN GEORGE FRYE				MONTH 2 DAY 16 YEAR 91				11:30 P.M.											
4. SOCIAL SECURITY NUMBER		5. SEX		8. AGE (In yrs. last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		7. DATE OF BIRTH		8. BIRTHPLACE (State or Foreign Country)							
130-01-9894		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		74 YRS.		MONTHS DAYS		HOURS MIN.		9/9/16		NY							
9a. FACILITY NAME (If not institution, give street and number)				9b. CITY, TOWN OR LOCATION OF DEATH				9c. COUNTY OF DEATH											
508 TRIPPE AVE.				EASTON				TALBOT											
RESIDENCE OF DECEDENT				10a. STATE				10b. COUNTY				10c. CITY, TOWN OR LOCATION				10d. INSIDE CITY LIMITS?			
				MD				TALBOT				EASTON				1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER				10f. ZIP CODE				10g. CITIZEN OF WHAT COUNTRY?											
508 TRIPPE AVE.				21601				USA											
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES?		13. WAS DECEDENT OF HISPANIC ORIGIN?		14. RACE — American Indian, Black, White, etc.													
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		Specify: White													
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		IF YES, GIVE WAR OR DATES		Specify:															
15. DECEDENT'S EDUCATION (Specify only highest grade completed)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY											
Elementary/Secondary (0-12)				College (1-4 or 5+)				ENGINEER				CHEMICAL ENGINEER							
12				4															
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)															
Percy Ellsworth Frye				Margaret George															
19a. INFORMANT'S NAME (Type/Print)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)															
Helen L. Frye				508 Trippe Ave. Easton, MD 21601															
20a. METHOD OF DISPOSITION				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)				20c. LOCATION — City or Town, State											
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State				Eastern Shore Crematorium				Georgetown, DE											
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)																			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE				22. NAME AND ADDRESS OF FACILITY															
M.E. Newman & Co. F.S.P.				Newnam Funeral Home															
				200 S. Harrison Easton, MD 21601															
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →												LONGSTANDING							
a. CARCINOMA PROSTATE, METASTATIC																			
DUE TO (OR AS A CONSEQUENCE OF):																			
b. DUE TO (OR AS A CONSEQUENCE OF):																			
c. DUE TO (OR AS A CONSEQUENCE OF):																			
d. DUE TO (OR AS A CONSEQUENCE OF):																			
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST																			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																			
24a. WAS AN AUTOPSY PERFORMED?														24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?					
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO														1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER?				26. PLACE OF DEATH (Check only one)															
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)															
27. MANNER OF DEATH				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK?		28d. DESCRIBE HOW INJURY OCCURRED									
1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined						M		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO											
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)										28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one)														29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year)			
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.														D35259		2/18/91			
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																			
29b. SIGNATURE AND TITLE OF CERTIFIER																			
KEVIN J. O'KEEFE, MD																			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)																			
KEVIN J. O'KEEFE, MD 606 PUTZMAN'S LANE, EASTON MD 21601																			
31. DATE FILED (Month, Day, Year)				32. REGISTRAR'S SIGNATURE															
FEB 19 '91				Julia Anderson-Randall															



91 05589

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Elaine Louise Faith</i>				2. DATE OF DEATH MONTH DAY YEAR <i>Feb. 21 1991</i>		3. TIME OF DEATH M <i>M</i>	
4. SOCIAL SECURITY NUMBER <i>217-32-6328</i>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>55</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>March 17, 1935</i>	
8. FACILITY NAME (If not institution, give street and number) <i>Washington County Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Hagerstown</i>		9c. COUNTY OF DEATH <i>Washington</i>	
RESIDENCE OF DECEDENT							
10a. STATE <i>MD</i>		10b. COUNTY <i>Washington</i>		10c. CITY, TOWN OR LOCATION <i>Smithsburg</i>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <i>Rt. 3 Box 391</i>				10f. ZIP CODE <i>21783</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Supervisor</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Sportswear Co.</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Welly C. Moser</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Lillian P. Tucker</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Deborah S. Reed</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>P.O. Box 233 Smithsburg, MD 21783</i>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Welly Church of the Brethren Cem.</i>		20c. LOCATION — City or Town, State <i>Greensburg, MD</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Pennie L. Davis</i>				22. NAME AND ADDRESS OF FACILITY <i>Davis Funeral Home Rt. 3 Box 78 Smithsburg, MD 21783</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		<i>Cerebrovascular Accident Thrombotic</i> DUE TO (OR AS A CONSEQUENCE OF) <i>Myocardial infarction</i> DUE TO (OR AS A CONSEQUENCE OF) <i>Coronary atherosclerosis</i> DUE TO (OR AS A CONSEQUENCE OF) <i>Chronic heart failure</i>					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Dilated Myocardium</i>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		25. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Undetermined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Samuel Chen, MD</i>				29c. LICENSE NUMBER <i>D 36655</i>		29d. DATE SIGNED (Month, Day, Year) <i>2/21/91</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Samuel Chen MD 1185 Mt. Aetna Rd. Hagerstown, MD 21740</i>							
31. DATE FILED (Month, Day, Year) <i>FEB 22 '91</i>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

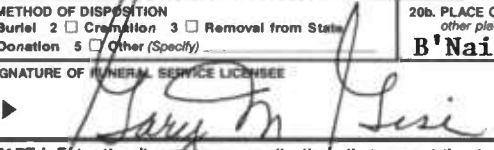
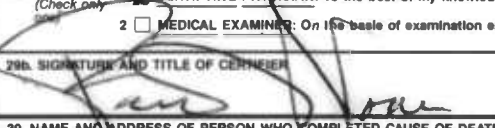
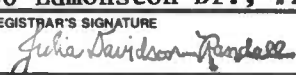
1 - FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				CERTIFICATE OF DEATH				REG. NO.							
1. DECEDENT'S NAME (First, Middle, Last) Gloria Virginia Grauman								2. DATE OF DEATH MONTH DAY YEAR 02 16 91				3. TIME OF DEATH 1:39 P.M.							
4. SOCIAL SECURITY NUMBER 578-22-1061				5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 66 YRS.		7. DATE OF BIRTH (Month, Day, Year) 07 19 24		8. BIRTHPLACE (State or Foreign Country) Washington D.C.									
9a. FACILITY NAME (If not institution, give street and number) 12904 Holdridge Road								9b. CITY, TOWN OR LOCATION OF DEATH Wheaton				9c. COUNTY OF DEATH Montgomery							
10a. STATE Maryland				10b. COUNTY Montgomery				10c. CITY, TOWN OR LOCATION Wheaton				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 12904 Holdridge Road								10f. ZIP CODE 20906				10g. CITIZEN OF WHAT COUNTRY? United States							
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: white							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Grant Technical Assistant				16b. KIND OF BUSINESS/INDUSTRY Gov't...N.I.H.											
17. FATHER'S NAME (First, Middle, Last) Richard Franklin Wine								18. MOTHER'S NAME (First, Middle, Maiden Surname) Olivia Jane Alexander											
19a. INFORMANT'S NAME (Type/Print) Robert R. Grauman								19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12904 Holdridge Road, Wheaton, MD 20906											
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Laytonsville Methodist Cemetery				20c. LOCATION — City or Town, State Laytonsville, MD											
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Paul M. Lee								22. NAME AND ADDRESS OF FACILITY Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. PNEUMONIA DUE TO (OR AS A CONSEQUENCE OF): b. PNEUMOCYSTIS CARINII DUE TO (OR AS A CONSEQUENCE OF): c. NOCARDIA ASTEROIDES DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 2 MOS 2 MOS 2 MOS												24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MENINGOENCEPHALITIS, MYCOBACTERIUM AVIUM-INTRACELLULAR INFECTION																			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)															
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29b. SIGNATURE AND TITLE OF CERTIFIER Edward A. Beeman MD				29c. LICENSE NUMBER D03604				29d. DATE SIGNED (Month, Day, Year) Feb. 18, 1991			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Edward A. Beeman M.D. 8830 Cameron St., Silver Spring, MD 20910																			
31. DATE FILED (Month, Day, Year) FEB 19 '91				32. REGISTRAR'S SIGNATURE John Davidson-Randall															

Sept 18 1864

91 05591

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>SOL GITAJN</b>				2. DATE OF DEATH MONTH <b>2</b> DAY <b>15</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>2:15 P.</b> M	
4. SOCIAL SECURITY NUMBER <b>579-42-5989</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		8. AGE (In yrs. last birthday) <b>76</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>1-15-1915</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Heritage Healthcare Center</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Takoma Park</b>		9c. COUNTY OF DEATH <b>Montgomery</b>			
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Rockville</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>199 Rollins Avenue</b>				10f. ZIP CODE <b>20852</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Business Owner</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Grocery</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Unknown</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Unknown</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Arthur S. Gitajn (Son)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4111 Blackpool Road; Rockville, Md. 20853-2010</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>B'Nai Israel Cemetery</b>		20c. LOCATION — City or Town, State <b>Oxon Hill, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY <b>Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike, Rockville, MD 20852</b>					
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Myocardial infarction</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Coronary artery disease</b>  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. b. c. d.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Rheumatoid arthritis</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>207471</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/15/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Paul T. Noone, M.D., 50 Edmonston Dr., #207, Rockville, MD 20852</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 20 '91</b>		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Handwritten text, possibly a signature or name, appearing in the middle section of the page.

Handwritten text, possibly a signature or name, appearing in the lower middle section of the page.

Handwritten text, possibly a signature or name, appearing in the bottom section of the page.

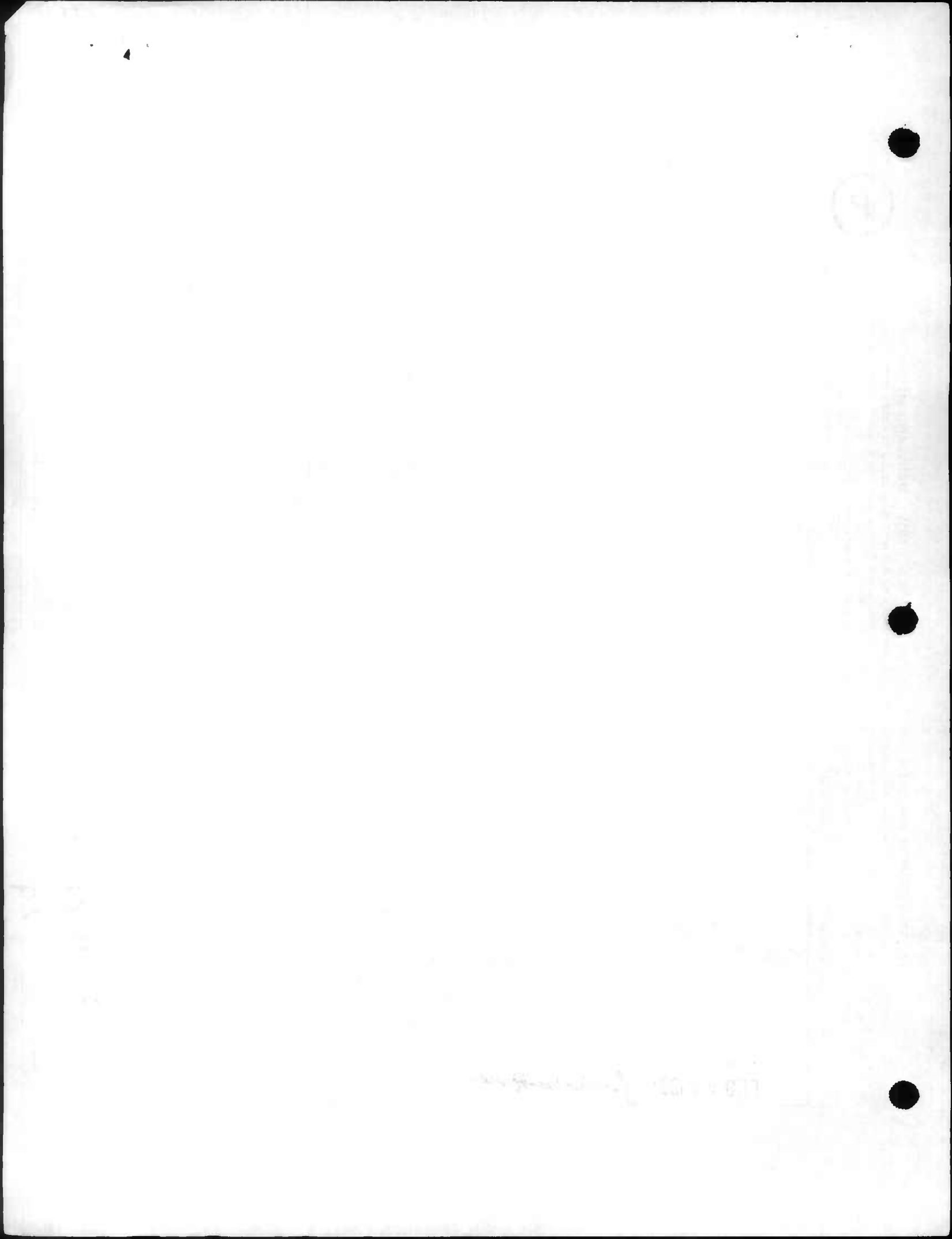
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2 & 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05592

1. DECEDENT'S NAME (First, Middle, Last) Arthur E. Garde Jr.				2. DATE OF DEATH MONTH DAY YEAR Feb 22, 1991		3. TIME OF DEATH 0612 M				
4. SOCIAL SECURITY NUMBER 212 30 7720		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 56 YRS.		7. DATE OF BIRTH (Month, Day, Year) 11-23-34		8. BIRTHPLACE (State or Foreign Country) MD		
9a. FACILITY NAME (If not institution, give street and number) Calvert Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Prince Frederick			9c. COUNTY OF DEATH Calvert			
10a. STATE MD		10b. COUNTY Calvert		10c. CITY, TOWN OR LOCATION Solomons			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER PO Box 386				10f. ZIP CODE 20688		10g. CITIZEN OF WHAT COUNTRY? USA				
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: white			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (14 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Electric Company			16b. KIND OF BUSINESS/INDUSTRY Utilities			
17. FATHER'S NAME (First, Middle, Last) Arthur Eberhardt Garde, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Florence Mason						
19a. INFORMANT'S NAME (Type/Print) Barbara L. Garde				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as 10 above						
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Lorraine Park		DATE 2 25 91		20c. LOCATION — City or Town, State Baltimore Maryland				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE B Rausch				22. NAME AND ADDRESS OF FACILITY Rausch Funeral Home Owings Maryland 20736						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. acute inferior and extensive ant. m.i. DUE TO (OR AS A CONSEQUENCE OF): b. Cardiac pnd. arrest. DUE TO (OR AS A CONSEQUENCE OF): c. CAD DUE TO (OR AS A CONSEQUENCE OF): d. C.H.F. Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER K. Yazdani M.D.				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) 2 22 1991				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) K. Yazdani, M.D. Prince Frederick, Maryland 20678										
31. DATE FILED (Month, Day, Year) FEB 25 1991				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall						



91 05593

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ROBERT JOSEPH GASTMAN				2. DATE OF DEATH MONTH DAY YEAR FEBRUARY 13, 1991		3. TIME OF DEATH 9:35A M	
4. SOCIAL SECURITY NUMBER 289-42-3234		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 44 YRS.		7. DATE OF BIRTH (Month, Day, Year) FEBRUARY 26, 1946	
9a. FACILITY NAME (If not institution, give street and number) 6204 Leeke Forest Court				9b. CITY, TOWN OR LOCATION OF DEATH BETHESDA		9c. COUNTY OF DEATH MONTGOMERY	
10a. STATE MARYLAND				10b. COUNTY MONTGOMERY		10c. CITY, TOWN OR LOCATION BETHESDA	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER 6204 LEEKE FOREST COURT				10f. ZIP CODE 20817		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Mortgage Banker		16b. KIND OF BUSINESS/INDUSTRY Health Care/Development			
17. FATHER'S NAME (First, Middle, Last) Norman Gastman				18. MOTHER'S NAME (First, Middle, Maiden Surname) Bessie Pearl Vessler			
19a. INFORMANT'S NAME (Type/Print) JANE H. GASTMAN				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6204 LEEKE FOREST COURT, BETHESDA, MARYLAND 20817			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Suburban Crematory		20c. LOCATION — City or Town, State Silver Spring, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ellen H. Rapp				22. NAME AND ADDRESS OF FACILITY Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → A. AIDS DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST B. DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF): D. DUE TO (OR AS A CONSEQUENCE OF):						Approximate interval between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide a <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER M. Wayne Saville MD				29c. LICENSE NUMBER MN 031562-7		29d. DATE SIGNED (Month, Day, Year) 2/13/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) M. Wayne Saville, 9000 ROCKVILLE PIKE, BETHESDA, MARYLAND 20892							
31. DATE FILED (Month, Day, Year) FEB 15 '91		32. REGISTRAR'S SIGNATURE Jana Davidson-Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





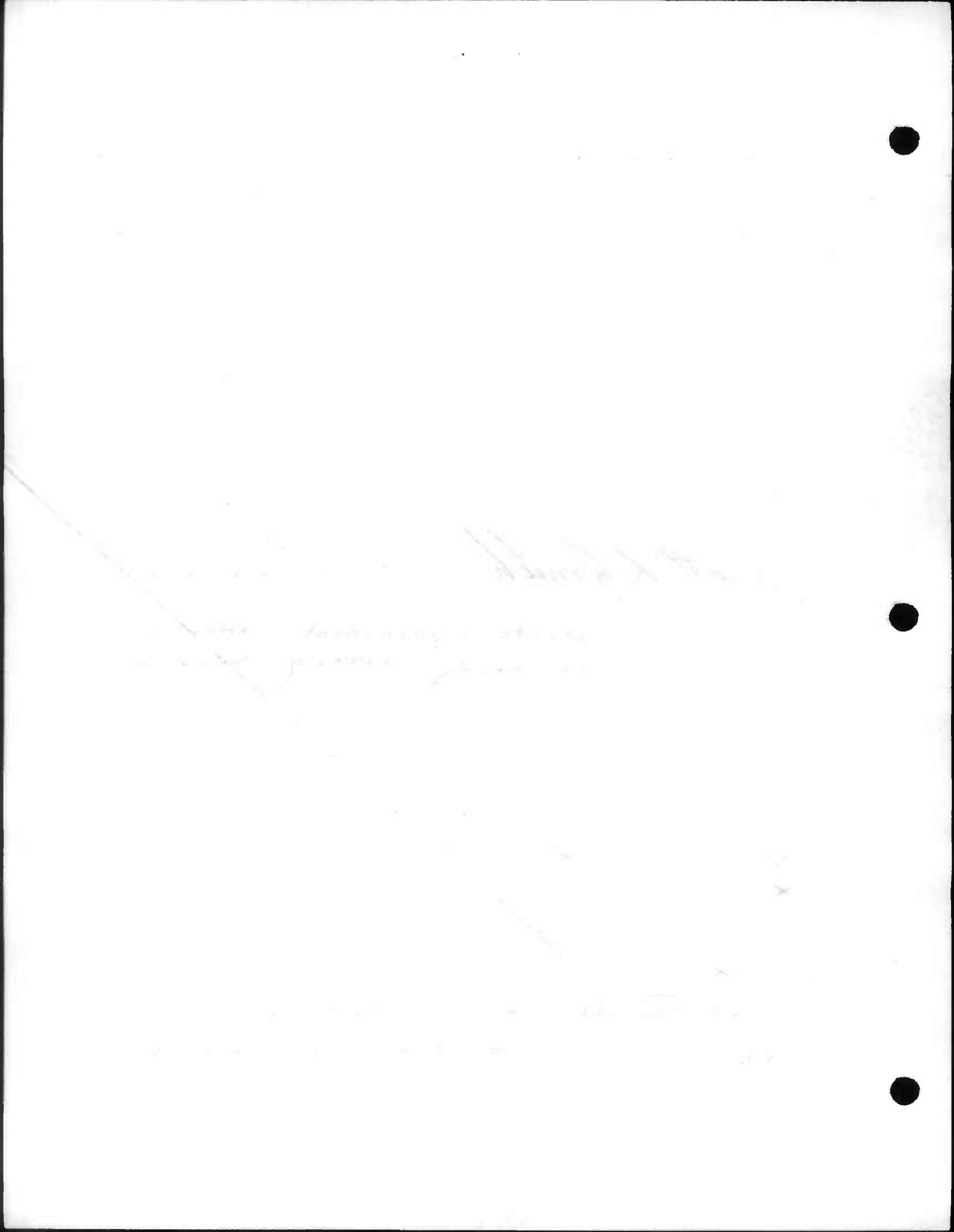
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05594

1. DECEDENT'S NAME (First, Middle, Last) <b>Charles Geimer, Sr.</b>				2. DATE OF DEATH MONTH <b>02</b> DAY <b>16</b> YEAR <b>91</b>		3. TIME OF DEATH <b>11:10 a.m.</b>				
4. SOCIAL SECURITY NUMBER <b>186-20-0168</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>62</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>MAY 17, 1928</b>		8. BIRTHPLACE (State or Foreign Country) <b>PENNSYLVANIA</b>		
9a. FACILITY NAME (If not institution, give street and number) <b>Montgomery General Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Olney</b>				9c. COUNTY OF DEATH <b>Montgomery</b>		
10a. STATE <b>MARYLAND</b>			10b. COUNTY <b>MONTGOMERY</b>			10c. CITY, TOWN OR LOCATION <b>OLNEY</b>			10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>18078 ROLLING MEADOW WAY</b>				10f. ZIP CODE <b>20832</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW II</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>ELECTRICIAN</b>			16b. KIND OF BUSINESS/INDUSTRY				
17. FATHER'S NAME (First, Middle, Last) <b>CHARLES SABASTIAN GEIMER</b>				16. MOTHER'S NAME (First, Middle, Maiden Surname) <b>EMMA MARIE SOMNER</b>						
19a. INFORMANT'S NAME (Type/Print) <b>STEVE C. GEIMER (SON)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3141 ASHWOOD DRIVE DUNKIRK, MARYLAND 20754</b>						
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>ARLINGTON NATIONAL CEMETERY</b>			20c. LOCATION — City or Town, State <b>ARLINGTON, VIRGINIA</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Francis J. Collins</i>				22. NAME AND ADDRESS OF FACILITY <b>FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W. SIL. SPR., MD. 20901</b>						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>acute myocardial infarction</b> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <b>coronary artery disease</b> c. d. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			26a. DATE OF INJURY (Month, Day, Year)		26b. TIME OF INJURY <b>M</b>		26c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. SIGNATURE AND TITLE OF CERTIFIER <i>John Tamber</i>				29c. LICENSE NUMBER <b>108946</b>		29d. DATE SIGNED (Month, Day, Year) <b>2-16-91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>John Tamber 2218 Wisconsin Ave Bethesda</b>										
31. DATE FILED (Month, Day, Year) <b>FEB 19 '91</b>			32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>							



91 05595

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MARGARET LILLIA DIANCOLA</b>		2. DATE OF DEATH MONTH <b>2</b> DAY <b>17</b> YEAR <b>91</b>		3. TIME OF DEATH <b>10:15 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>578-03-7636</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>81 YRS.</b>	
7. DATE OF BIRTH (Month, Day, Year) <b>SEPT. 25, 1909</b>		8. BIRTHPLACE (State or Foreign Country) <b>MASSACHUSETTS</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>HOLY CROSS HOSPITAL</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>SILVER SPRING</b>		9c. COUNTY OF DEATH <b>MONTGOMERY</b>	
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>MONTGOMERY</b>		10c. CITY, TOWN OR LOCATION <b>BETHESDA</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>7825 RIVER ROAD</b>		10f. ZIP CODE <b>20817</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HAIRDRESSER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>BEAUTY SHOP</b>	
17. FATHER'S NAME (First, Middle, Last) <b>RALPH POLSELLI</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>CARMELA Di CICCIO</b>			
19a. INFORMANT'S NAME (Type/Print) <b>PAUL NIGLIO (NEPHEW)</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1601 BRISBANE STREET, SILVER SPRING, MARYLAND 20902</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>GATE OF HEAVEN CEMETERY</b>		20c. LOCATION — City or Town, State <b>SILVER SPRING, MARYLAND</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>		22. NAME AND ADDRESS OF FACILITY <b>FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W., SIL.SP., MD 20901</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiovascular - Atherosclerosis</b> DUE TO (OR AS A CONSEQUENCE OF): Atherosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Obesity</b>					Approximate Interval Between Onset and Death <b>15 m.</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Obesity</b>					24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <b>2/12/91</b>	
28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> M.D.		29c. LICENSE NUMBER <b>000232</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/12/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Morton Altschuler M.D. 1299 - Kensington Dr. Silver Spring, Md 20902</b>					
31. DATE FILED (Month, Day, Year) <b>FEB 19 '91</b>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

*[Faint, illegible handwriting]*

*[Faint, illegible handwriting]*

*[Faint, illegible handwriting]*

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05596

1. DECEDENT'S NAME (First, Middle, Last) <u>Sigmund Goldstein</u>				2. DATE OF DEATH MONTH <u>2</u> DAY <u>12</u> YEAR <u>91</u>		3. TIME OF DEATH <u>8:07 A.</u>	
4. SOCIAL SECURITY NUMBER <u>041-32-6674</u>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>86</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>11/12/04</u>	
8. BIRTHPLACE (State or Foreign Country) <u>Czechoslovakia</u>		9a. FACILITY NAME (If not institution, give street and number) <u>Hebrew Home of Greater Washington</u>		9b. CITY, TOWN OR LOCATION OF DEATH <u>Rockville</u>		9c. COUNTY OF DEATH <u>Montgomery</u>	
10a. STATE <u>MD</u>		10b. COUNTY <u>Montgomery</u>		10c. CITY, TOWN OR LOCATION <u>Rockville</u>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <u>6105 Montrose Rd.,</u>				10f. ZIP CODE <u>20852</u>		10g. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>College</u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Restaurant Owner</u>		16b. KIND OF BUSINESS/INDUSTRY <u>Sig's Deli</u>			
17. FATHER'S NAME (First, Middle, Last) <u>Wolf Goldstein</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Esther Kleiman</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Bill Goldstein, Son</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>3101 New Mexico Ave., NW, #1101, Wash. D.C. 20016</u>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <u>King David Memorial Garden</u>		20c. LOCATION — City or Town, State <u>Falls Church, VA</u>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Frank A. Stone</u>				22. NAME AND ADDRESS OF FACILITY <u>Danzansky-Goldberg Memorial Chapels</u> <u>1170 Rockville Pike, Rockville, MD 20852</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Ischemic Colitis</u> DUE TO (OR AS A CONSEQUENCE OF): a. <u>Generalized Atherosclerotic Disease</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>Hypertension</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>Sip Cerebral Vascular Accident</u> Approximate Interval Between Onset and Death <u>1986</u>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Sip Sigmoid Colon Resection for Volvulus</u> <u>Sip Bilateral Orchiectomy. Dementia (Multi-Infarct)</u>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Nomicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Susan J. Miller MD</u>				29c. LICENSE NUMBER <u>D35579</u>		29d. DATE SIGNED (Month, Day, Year) <u>2/12/91</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>Susan J. Miller, MD The Hebrew Home of Greater Washington 6121 Montrose Rd, Rockville, MD 20852</u>							
31. DATE FILED (Month, Day, Year) <u>FEB 14 '91</u>				32. REGISTRAR'S SIGNATURE <u>Guth Davidson-Rendell</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 05597

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Kermit Roe Galford				2. DATE OF DEATH MONTH DAY YEAR 2-20-91		3. TIME OF DEATH 5:40 p.m.	
4. SOCIAL SECURITY NUMBER 236-18-5697		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 72 YRS.		7. DATE OF BIRTH (Month, Day, Year) 11-25-18	
8. BIRTHPLACE (State or Foreign Country) W. Virginia				9a. CITY, TOWN OR LOCATION OF DEATH Severna Park		9c. COUNTY OF DEATH Anne Arundel	
9b. FACILITY NAME (If not Institution, give street and number) Meridian Nursing Center				10a. STATE MD			
10b. COUNTY Anne Arundel				10c. CITY, TOWN OR LOCATION Glen Burnie			
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 17 Thomas Rd.			
10f. ZIP CODE 21061				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Owner/Operator		16b. KIND OF BUSINESS/INDUSTRY Galford Contracting Co.			
17. FATHER'S NAME (First, Middle, Last) Jesse O. Galford				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ella Mae Keener			
19a. INFORMANT'S NAME (Type/Print) Katherine Trueman Galford				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17 Thomas Rd. Glen Burnie MD 21061			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Lake Lane Cemetery		20c. LOCATION — City or Town, State (near) Heaters, W.Va.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Katherine Trueman Galford</i>				22. NAME AND ADDRESS OF FACILITY 495 Ritchie Highway Barranco & Sons F.H. Severna Park MD 21146			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Cardiorespiratory arrest</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <i>Broncho pneumonia</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>ASCVD</i> DUE TO (OR AS A CONSEQUENCE OF): d. <i>parkinsonism Dementia</i>						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>arterio sclerosis</i>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Murphy Ann Quinn</i>				29c. LICENSE NUMBER D 22206		29d. DATE SIGNED (Month, Day, Year) 2 2 91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 273 B <i>peninsula lane rd</i> <i>Arnold MD 21016</i>							
31. DATE FILED FEB 22 1991							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, and 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				91 05598					
CERTIFICATE OF DEATH				REG. NO.									
1. DECEDENT'S NAME (First, Middle, Last) William Grunden				2. DATE OF DEATH MONTH 2 DAY 11 YEAR 91				3. TIME OF DEATH 9:14 p.m.					
4. SOCIAL SECURITY NUMBER 215-26-4822		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		8. AGE (In yrs. last birthday) 83 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) 8/3/07		8. BIRTHPLACE (State or Foreign Country) PA	
9a. FACILITY NAME (If not institution, give street and number) Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Easton				9c. COUNTY OF DEATH Talbot					
RESIDENCE OF DECEDENT													
10a. STATE MD		10b. COUNTY Talbot		10c. CITY, TOWN OR LOCATION Easton				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO					
10e. STREET AND NUMBER 367 Glebe Road				10f. ZIP CODE 21601				10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: white					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10th		College (1-4 or 5 +) College (1-4 or 5 +)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Painter				16b. KIND OF BUSINESS/INDUSTRY					
17. FATHER'S NAME (First, Middle, Last) Rex Grunden				18. MOTHER'S NAME (First, Middle, Maiden Surname) Sarah Wilson									
19a. INFORMANT'S NAME (Type/Print) Bertha Grunden				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 367 Glebe Rd. Easton, MD 21601									
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Woodlawn 2/15		DATE 2/15		20c. LOCATION — City or Town, State Easton, MD							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE JOHN R. MERCERON				22. NAME AND ADDRESS OF FACILITY Newnam Funeral Home 200 S. Harrison St. Easton, MD									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory failure b. metabolic + lactic acidosis c. profound hypotension d. suspected carcinoma of pancreas Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. COPD										Approximate Interval Between Onset and Death 48 hrs.			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER Albert T. Dawkins Jr.				29c. LICENSE NUMBER D02824				29d. DATE SIGNED (Month, Day, Year) 2/12/91					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ALBERT T. DAWKINS JR. 308 IDE WILD AVE EASTON MARYLAND 21601													
31. DATE FILED (Month, Day, Year) FEB 13 '91				32. REGISTRAR'S SIGNATURE John R. Mercer									



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, & 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05599

1. DECEDENT'S NAME (First, Middle, Last) Charles Addison Gibson				2. DATE OF DEATH MONTH DAY YEAR 2 3 1991		3. TIME OF DEATH 3:10P M				
4. SOCIAL SECURITY NUMBER 220-01-0347		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 81 YRS.		7. DATE OF BIRTH (Month, Day, Year) 7/8/09		8. BIRTHPLACE (State or Foreign Country) Md.		
9a. FACILITY NAME (If not institution, give street and number) Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Easton			9c. COUNTY OF DEATH Talbot			
10a. STATE Md.		10b. COUNTY Talbot		10c. CITY, TOWN OR LOCATION Easton			10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER 701 Dyerbrook Apts.				10f. ZIP CODE 21601		10g. CITIZEN OF WHAT COUNTRY? USA				
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: Blk			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input checked="" type="checkbox"/> College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Truck driver			16b. KIND OF BUSINESS/INDUSTRY Trucking					
17. FATHER'S NAME (First, Middle, Last) Charles Gibson				18. MOTHER'S NAME (First, Middle, Maiden Surname) Maggie Slaughter						
19a. INFORMANT'S NAME (Type/Print) Wanda Adams				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 611 August St. Easton, Md. 21601						
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Paradise		DATE 2/9/91		20c. LOCATION — City or Town, State Trappe, Md.				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Funeral services 319 Dyer St. Easton, Md. 21601						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>ventricular arrhythmia</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>acute myocardial infarction</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>coronary atherosclerosis</u> DUE TO (OR AS A CONSEQUENCE OF): d. Sequently ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>cardiomyopathy &amp; CHF</u> <u>COPD &amp; bronchospasm</u>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER M.D.				29c. LICENSE NUMBER 025750		29d. DATE SIGNED (Month, Day, Year) 2-4-91		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) R.B. Sanchez 509 Idwell Ave Easton, MD 21601										
31. DATE FILED (Month, Day, Year) FEB - 5 '91		32. REGISTRAR'S SIGNATURE 								

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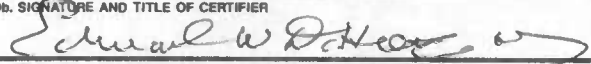
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05600

1. DECEDENT'S NAME (First, Middle, Last) <b>Laura Gladys GODLOVE</b>		2. DATE OF DEATH MONTH DAY YEAR <b>February 18, 1991</b>		3. TIME OF DEATH Approx. <b>6:00 a.m.</b>	
4. SOCIAL SECURITY NUMBER	5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>82</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>July 18, 1903</b>		8. BIRTHPLACE (State or Foreign Country) <b>West Virginia</b>
9a. FACILITY NAME (If not institution, give street and number) <b>Washington County Hospital</b>			9b. CITY, TOWN OR LOCATION OF DEATH <b>Hagerstown</b>		9c. COUNTY OF DEATH <b>Washington</b>
RESIDENCE OF DECEDENT					
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Washington</b>		10c. CITY, TOWN OR LOCATION <b>Hagerstown</b>	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
10e. STREET AND NUMBER <b>Washington Apts. 1010C, Security Rd.</b>			10f. ZIP CODE <b>21740</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <b>James C. Godlove</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Ann Roche</b>			
19a. INFORMANT'S NAME (Type/Print)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Rose Hill Cemetery</b>		20c. LOCATION — City or Town, State <b>Hagerstown, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY <b>MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Arteriosclerotic Cardiovascular Disease</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.					Approximate Interval Between Onset and Death <b>Many Yrs.</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
					24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER 			29c. LICENSE NUMBER <b>DO1062</b>		29d. DATE SIGNED (Month, Day, Year) <b>Feb. 19, 1991</b>
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Edward W. Ditto, III, M.D., 217 West Washington Street, Hagerstown, Maryland 21740</b>					
31. DATE FILED (Month, Day, Year) <b>FEB 20 91</b>					



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05601

1. DECEDENT'S NAME (First, Middle, Last) CLARA D. HOFFMAN				2. DATE OF DEATH MONTH DAY YEAR FEBRUARY 15, 1991		3. TIME OF DEATH 9:50 A M				
4. SOCIAL SECURITY NUMBER 218-24-1018		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) YRS. MONTHS DAYS 90		7. DATE OF BIRTH (Month, Day, Year) APRIL 28, 1900		8. BIRTHPLACE (State or Foreign Country) WASHINGTON, D.C.		
9a. FACILITY NAME (If not institution, give street and number) HOLY CROSS HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH SILVER SPRING			9c. COUNTY OF DEATH MONTGOMERY			
10a. STATE MARYLAND		10b. COUNTY PRINCE GEORGE'S		10c. CITY, TOWN OR LOCATION MT. RAINIER			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER 4202 28TH STREET				10f. ZIP CODE 20710		10g. CITIZEN OF WHAT COUNTRY? USA				
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: WHITE			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE		16b. KIND OF BUSINESS/INDUSTRY						
17. FATHER'S NAME (First, Middle, Last) GEORGE OFENSTEIN				18. MOTHER'S NAME (First, Middle, Maiden Surname) MARGARET SMITH						
19a. INFORMANT'S NAME (Type/Print) WILLIAM J. HOFFMAN, JR. (SON)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19025 MILLS CHOICE ROAD #5 GAITHERSBURG, MD. 20879						
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) MT. OLIVET CEMETERY		20c. LOCATION — City or Town, State WASHINGTON, D.C.						
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Francis J. Collins</i>				22. NAME AND ADDRESS OF FACILITY FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W. SIL. SPR., MD. 20901						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardio-Pulmonary arrest DUE TO (OR AS A CONSEQUENCE OF): b. Cardiac arrhythmia DUE TO (OR AS A CONSEQUENCE OF): c. Atherosclerotic heart disease DUE TO (OR AS A CONSEQUENCE OF): d. Hypertension Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Aortic aneurysm Cholelithiasis.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) NA		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED		
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER <i>MD</i>				29c. LICENSE NUMBER D19609		29d. DATE SIGNED (Month, Day, Year) 2-16-91				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) RAMAN R. TULL, 3503 PERRY ST., MT. RAINIER, MD 20722										
31. DATE FILED (Month, Day, Year) FEB 19 '91				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Russell</i>						

2nd Floor



91 05602

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>EUGENE F. HAGOOD</b>			2. DATE OF DEATH MONTH <b>02</b> DAY <b>13</b> YEAR <b>91</b>		3. TIME OF DEATH <b>1:20 P M</b>
4. SOCIAL SECURITY NUMBER <b>5-79-40-1940</b>	5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) YRS. MONTHS DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) <b>7-21-34</b>		8. BIRTHPLACE (State or Foreign Country) <b>WASH. D.C.</b>
9a. FACILITY NAME (If not institution, give street and number) <b>SOUTHERN MARYLAND HOSPITAL</b>			9b. CITY, TOWN OR LOCATION OF DEATH <b>CLINTON</b>		9c. COUNTY OF DEATH <b>PRINCE GEORGES</b>
10a. STATE <b>MD</b>		10b. COUNTY <b>PRINCE GEORGES</b>	10c. CITY, TOWN OR LOCATION <b>FT WASHINGTON</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
10e. STREET AND NUMBER <b>8913 LOUGHRAN TERR.</b>			10f. ZIP CODE <b>20747</b>	10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>MECHANIC</b>		16b. KIND OF BUSINESS/INDUSTRY <b>APPLIANCE REPAIR</b>			
17. FATHER'S NAME (First, Middle, Last) <b>LUTHER HAGOOD</b>			18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ESSIE MOSES</b>		
19a. INFORMANT'S NAME (Type/Print) <b>LILLIAN HUMPHREY</b>			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6506 PIN OAK CT. CLINTON, MD 20735</b>		
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>HARMONY CEMETERY 2-19-91 LANDOVER, MD</b>		20c. LOCATION — City or Town, State <b>W.W. CHAMBERS CO. WASH. DC</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>W.W. Chambers</b> M00091			22. NAME AND ADDRESS OF FACILITY <b>W.W. CHAMBERS CO. 517 11th ST. SE, WASH. DC</b>		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ADULT RESPIRATORY DISTRESS SYNDROME</b> DUE TO (OR AS A CONSEQUENCE OF): a. <b>SEPSIS</b> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST					Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>GASTRIC CARCINOMA</b>					24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
					24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Sayer M</b>			29c. LICENSE NUMBER <b>D28281</b>	29d. DATE SIGNED (Month, Day, Year) <b>2/13/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>NEILSON BENJERS MD, 9015 WOODWARD RD, CLINTON, MD 20735</b>					
31. DATE FILED (Month, Day, Year) <b>FEB 20 '91</b>		32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

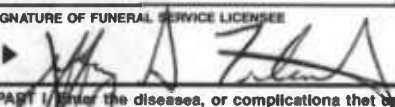
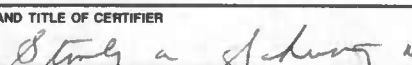
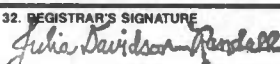
1 - FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH				3. TIME OF DEATH			
Shirlee R. HUTMIRE				2-15-91				18:39 M			
4. SOCIAL SECURITY NUMBER		5. SEX		8. AGE (In yrs. last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		7. DATE OF BIRTH	
043 26 2200		1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F		59 YRS.		MONTHS DAYS		HOURS MIN.		Jan. 15 1932	
9a. FACILITY NAME (If not institution, give street and number)				9b. CITY, TOWN OR LOCATION OF DEATH				9c. COUNTY OF DEATH			
Washington Adventist Hospital				Takoma Park				Montgomery			
10a. STATE		10b. COUNTY		10c. CITY, TOWN OR LOCATION				10d. INSIDE CITY LIMITS?			
Maryland		Montgomery		Takoma Park				1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER				10f. ZIP CODE				10g. CITIZEN OF WHAT COUNTRY?			
7412 Holly Avenue				20912				U.S.A.			
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES?		13. WAS DECEDENT OF HISPANIC ORIGIN?		14. RACE — American Indian, Black, White, etc.					
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		Specify: White					
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		IF YES, GIVE WAR OR DATES		If yes, specify Cuban, Mexican, Puerto Rican, etc.)							
15. DECEDENT'S EDUCATION (Specify only highest grade completed)				18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY			
Elementary/Secondary (9-12) 12				College (1-4 or 5+) 4				Homemaker			
								At Home			
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)							
Earl King Rhodes				Christena Hunter							
19a. INFORMANT'S NAME (Type/Print)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)							
Edward W. Hutmire				7412 Holly Avenue, Takoma Park, MD., 20912							
20a. METHOD OF DISPOSITION		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)		20c. LOCATION — City or Town, State							
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State		Metropolitan Crematory		Alexandria, VA.							
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)											
21. SIGNATURE OF FUNERAL SERVICE LICENSEE				22. NAME AND ADDRESS OF FACILITY							
Julian Seale				TAKOMA FUNERAL HOME, INC.							
				254 Carroll St. N.W. Washington DC							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate interval between Onset and Death			
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. metastatic carcinoma of lung								4 mos			
DUE TO (OR AS A CONSEQUENCE OF):											
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST											
b. DUE TO (OR AS A CONSEQUENCE OF):											
c. DUE TO (OR AS A CONSEQUENCE OF):											
d. DUE TO (OR AS A CONSEQUENCE OF):											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED?			
								1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
								1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER?				26. PLACE OF DEATH (Check only one)							
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA				OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK?		28d. DESCRIBE HOW INJURY OCCURRED	
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide						M		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined											
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one)											
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUMBER				29d. DATE SIGNED (Month, Day, Year)			
Martin O. Uelitz				P23473				2/16/91			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)											
MARTIN WERTZ 7525 Greenway Ct Drum Greenbelt MD 20770											
31. DATE FILED (Month, Day, Year)				32. REGISTRAR'S SIGNATURE							
FEB 20 '91				Julia Davidson-Randall							



91 05604

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Marjorie E. Holmes				2. DATE OF DEATH MONTH DAY YEAR February 16, 1991		3. TIME OF DEATH 12:32P M	
4. SOCIAL SECURITY NUMBER 211-10-9341		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 73 YRS.		7. DATE OF BIRTH (Month, Day, Year) Dec. 3, 1917	
8. BIRTHPLACE (State or Foreign Country) Pennsylvania				9a. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring	
9c. COUNTY OF DEATH Montgomery				10a. STATE Maryland		10b. COUNTY Montgomery	
10c. CITY, TOWN OR LOCATION Silver Spring				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 3406 Glorus Place	
10f. ZIP CODE 20902				10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) -				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Office Manager		16b. KIND OF BUSINESS/INDUSTRY Kelly Services	
17. FATHER'S NAME (First, Middle, Last) John H. Stahl				18. MOTHER'S NAME (First, Middle, Maiden Surname) Emma Weaver			
19a. INFORMANT'S NAME (Type/Print) Janet S. Evans				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 118 Church Road, Kingston Township, PA, 18644			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Montoursville Cemetery 2/20		20c. LOCATION — City or Town, State Montoursville, PA	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  M00689				22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>S1200M</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>Metastatic cancer</u> c. <u>inspiration</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>Breast Cancer</u> DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D1768		29d. DATE SIGNED (Month, Day, Year) 2/17/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Stanley A. Schwartz, M.D. 5454 Wisconsin Avenue, #835, Chevy Chase, MD 20815							
31. DATE FILED (Month, Day, Year) FEB 19 '91				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05605

1. DECEDENT'S NAME (First, Middle, Last) <b>MERNA HORNE</b>				2. DATE OF DEATH MONTH DAY YEAR <b>2/11/91</b>		3. TIME OF DEATH M <b>10:33 a.</b>					
4. SOCIAL SECURITY NUMBER <b>495 24 9561</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>87</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>5/25/03</b>		8. BIRTHPLACE (State or Foreign Country) <b>Kansas</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Montgomery General Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Olney</b>				9c. COUNTY OF DEATH <b>Montgomery</b>			
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Silver Spring</b>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER <b>3512 Fiske Terrace</b>				10f. ZIP CODE <b>20906</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify <b>White</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>1/12</b> College (1-4 or 5+) <b>4 Years</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Teacher</b>		16b. KIND OF BUSINESS/INDUSTRY <b>High School</b>							
17. FATHER'S NAME (First, Middle, Last) <b>Robert Crabtree</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Bertha Royer</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Joan K. Buchman</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>18685 Hanna Drive Cupertino, California</b>							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Scott County Cemetery</b>		20c. LOCATION — City or Town, State <b>Scott City, Kansas</b>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Louis L. Grant</i>				22. NAME AND ADDRESS OF FACILITY <b>Hines/Rimaldi 11800 New Hamp. Ave. S.S. Md.</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardio Pulmonary arrest</b> Approximate Interval Between Onset and Death <b>immediate</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <b>Cardiogenic Shock</b> <b>24 Hrs</b> b. <b>Hypotension</b> <b>24 Hrs</b> c. <b>Hypovolemia, Hypoproteinemia,</b> <b>months</b> d. <b>Hypovolemia, Hypoproteinemia,</b> PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Renal Failure, malnutrition, Depression</b>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>Oliver Lawless, M.D.</b>				29c. LICENSE NUMBER <b>D25410</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/11/91</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>O.J. Lawless MD 3501 International Drive, Silver Spring MD 20906</b>											
31. DATE FILED (Month, Day, Year) <b>FEB 15 '91</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>							

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <b>MELVIN A. HOGAN</b>		2. DATE OF DEATH MONTH <b>2</b> - DAY <b>16</b> - YEAR <b>91</b>		3. TIME OF DEATH <b>8:05 PM</b>	
4. SOCIAL SECURITY NUMBER <b>213-03-0251</b>		5. SEX <b>1</b> <input checked="" type="checkbox"/> M <b>2</b> <input type="checkbox"/> F		6. AGE (in yrs. last birthday) <b>81</b> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <b>Feb. 11, 1910</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Montgomery General Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Olney</b>		9c. COUNTY OF DEATH <b>Montgomery</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Ashton</b>	
10d. INSIDE CITY LIMITS? <b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>17700 New Hampshire Avenue</b>		10f. ZIP CODE <b>20861</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <b>1</b> <input type="checkbox"/> Never Married <b>2</b> <input type="checkbox"/> Married <b>3</b> <input checked="" type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WWII</b>	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>1-8th.</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Supervisor</b>		16b. KIND OF BUSINESS/INDUSTRY <b>WSSC</b>	
17. FATHER'S NAME (First, Middle, Last) <b>(Unknown) Hogan</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>(Unknown)</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Gregory A. Hogan</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>#15 Tynewick Ct., Silver Spring, Md. 20906</b>			
20a. METHOD OF DISPOSITION <b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State <b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Union Cemetery</b>		20c. LOCATION — City or Town, State <b>Burtonsville, Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>		22. NAME AND ADDRESS OF FACILITY <b>Hines/Rinaldi Funeral Home</b> <b>11800 N.H. Ave., Silver Spring, Md. 20904</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiac arrhythmia.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. <b>Due to (or as a consequence of):</b> <b>Bowel obstruction.</b> b. <b>Due to (or as a consequence of):</b> <b>Incarcerated right inguinal</b> c. <b>Due to (or as a consequence of):</b> <b>hernia.</b> d.					Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					24a. WAS AN AUTOPSY PERFORMED? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO
					24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA OTHER: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation <b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined <b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
		28c. INJURY AT WORK? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <b>1</b> <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>		29c. LICENSE NUMBER <b>708546</b>		29d. DATE SIGNED (Month, Day, Year) <b>2-12-91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>John Tauber 8218 Wisconsin Ave. Bethesda Md.</b>					
31. DATE FILED (Month, Day, Year) <b>FEB 19 '91</b>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Handwritten text, possibly a title or header, located in the upper middle section of the page.

Table with multiple columns and rows of handwritten data, located in the lower middle section of the page.

Column 1	Column 2	Column 3	Column 4	Column 5
1	2	3	4	5
6	7	8	9	10
11	12	13	14	15
16	17	18	19	20
21	22	23	24	25
26	27	28	29	30
31	32	33	34	35
36	37	38	39	40
41	42	43	44	45
46	47	48	49	50
51	52	53	54	55
56	57	58	59	60
61	62	63	64	65
66	67	68	69	70
71	72	73	74	75
76	77	78	79	80
81	82	83	84	85
86	87	88	89	90
91	92	93	94	95
96	97	98	99	100

Handwritten text, possibly a signature or footer, located in the lower right section of the page.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				CERTIFICATE OF DEATH				REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last) <i>HONSA, EDITH</i> EDITH HONSA						2. DATE OF DEATH MONTH <i>2</i> DAY <i>13</i> YEAR <i>91</i>		3. TIME OF DEATH <i>6:50</i> P <sup>M</sup>							
4. SOCIAL SECURITY NUMBER <i>274-40-1768</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <i>86</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) <i>JAN. 12, 1905</i>		8. BIRTHPLACE (State or Foreign Country) <i>WISCONSIN</i>					
9a. FACILITY NAME (If not institution, give street and number) <i>SACRED HEART HOME</i>						9b. CITY, TOWN OR LOCATION OF DEATH <i>HYATTSVILLE</i>				9c. COUNTY OF DEATH <i>PRINCE GEORGE'S</i>					
10a. STATE <i>MARYLAND</i>		10b. COUNTY <i>MONTGOMERY</i>		10c. CITY, TOWN OR LOCATION <i>SILVER SPRING</i>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO							
10e. STREET AND NUMBER <i>311 LANARK WAY</i>				10f. ZIP CODE <i>20901</i>		10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>									
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <i>WHITE</i>							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>8</i> Elementary/Secondary (0-12)		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>HOMEMAKER</i>		15b. KIND OF BUSINESS/INDUSTRY											
17. FATHER'S NAME (First, Middle, Last) <i>FERDINAND HINGISS</i>						18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>ANNA BECHERER</i>									
19a. INFORMANT'S NAME (Type/Print) <i>JEANETTE HONSA (DAUGHTER)</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>508 BONIFANT STREET SILVER SPRING, MARYLAND 20910</i>											
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <i>GATE OF HEAVEN CEMETERY</i>				20c. LOCATION — City or Town, State <i>SILVER SPRING, MARYLAND</i>									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <i>FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W. SIL. SPR., MD. 20901</i>											
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>pneumonia</i> DUE TO (OR AS A CONSEQUENCE OF):  Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <i>Aspiration</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death <i>DAYS</i> <i>DAYS</i>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>SEVERE DRUNKENIA for years</i>															
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)													
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED							
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>		29c. LICENSE NUMBER <i>D22780</i>		29d. DATE SIGNED (Month, Day, Year) <i>2/14/91</i>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>P. SCHLOSSER MD 7500 Greenway Ctr Dr. Greenbelt Md</i>															
31. DATE FILED (Month, Day, Year) <i>FEB 19 '91</i>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>													



91 05608

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Maria Emilia AKA: Helser</i>				2. DATE OF DEATH MONTH DAY YEAR <i>2 - 12 - 91</i>		3. TIME OF DEATH <i>1555 P.M.</i>	
4. SOCIAL SECURITY NUMBER <i>527 63 4537</i>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>40</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>8 16 1950</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Shady Grove Adventist Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Rockville</i>		9c. COUNTY OF DEATH <i>Montgomery</i>	
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Montgomery</i>		10c. CITY, TOWN OR LOCATION <i>Silver Spring</i>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <i>11905 Crimson Lane</i>		10f. ZIP CODE <i>20904</i>		10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>Peruvian</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <i>2</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Translator</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Travel</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Enrique Navarrete</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Emilia Pasco de Navarrete</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Emilia Navarrete</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>General Cordova 2562 Lima 14 Peru</i>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Metropolitan Crematory</i>		20c. LOCATION — City or Town, State <i>Alexandria, Va.</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <i>Francis J. Collins INC. 500 University Blvd. W. Sil. Spr. Md. 20901</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Sepsis</i> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <i>Systemic Lupus Erythematosus</i> c. d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Chronic Constrictive Pericarditis</i>						Approximate Interval Between Onset and Death	
24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Carolyn L. Baier</i>				29c. LICENSE NUMBER <i>D 34386</i>		29d. DATE SIGNED (Month, Day, Year) <i>2/14/91</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Carolyn L. Baier, M.D. 15225 Shady Grove Road #105 Rockville, Md. 20850</i>							
31. DATE FILED (Month, Day, Year) <i>FEB 19 '91</i>		32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				REG. NO.							
1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH MONTH DAY YEAR				3. TIME OF DEATH H M A M							
Dorothy T. Hanback				2 12 1991				8:37 A M							
4. SOCIAL SECURITY NUMBER 577-62-9982		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) 3-4-1903		8. BIRTHPLACE (State or Foreign Country) Washington, D.C.			
9a. FACILITY NAME (If not institution, give street and number) Reeders Memorial Home						9b. CITY, TOWN OR LOCATION OF DEATH Boonsboro				9c. COUNTY OF DEATH Washington					
10a. STATE Maryland				10b. COUNTY Montgomery				10c. CITY, TOWN OR LOCATION Gaithersburg				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 419 Christopher Avenue, #12						10f. ZIP CODE 20879				10g. CITIZEN OF WHAT COUNTRY? United States					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Clerk				16b. KIND OF BUSINESS/INDUSTRY United States Treasury Department							
17. FATHER'S NAME (First, Middle, Last) Charles Sparks						18. MOTHER'S NAME (First, Middle, Maiden Surname) Cora Howard									
19a. INFORMANT'S NAME (Type/Print) Jean M. Garland						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 419 Christopher Avenue, #12, Gaithersburg, MD 20879									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Cedar Hill Cemetery				20c. LOCATION — City or Town, State Suitland, Maryland							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Barbara J. McMullen Lawrence				22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/ Rockville, Inc., 300 West Montgomery Avenue, Rockville, Maryland 20850-2805											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CVA Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.										Approximate Interval Between Onset and Death 3 days					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ABAND. CORP. 035 Hypothetical										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER V. J. Davidson						29c. LICENSE NUMBER D 18019			29d. DATE SIGNED (Month, Day, Year) 2-12-91						
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) V. J. Davidson, MD 336 Mill St Hagerstown, MD 21740															
31. DATE FILED (Month, Day, Year) FEB 19 '91				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall											





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				91 05610					
CERTIFICATE OF DEATH				REG. NO.									
1. DECEDENT'S NAME (First, Middle, Last) Samuel M. Hyde				2. DATE OF DEATH MONTH DAY YEAR 2-18-1991				3. TIME OF DEATH M					
4. SOCIAL SECURITY NUMBER 218-16-2334		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 65 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH MONTH DAY YEAR 4-28-1925		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) 4931 Mountain Rd.				9b. CITY, TOWN OR LOCATION OF DEATH Pasadena				9c. COUNTY OF DEATH Anne Arundel					
10a. STATE Md.				10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Pasadena				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 4931 Mountain Rd.				10f. ZIP CODE 21122				10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Machinist				16b. KIND OF BUSINESS/INDUSTRY Hydrasearch Inc.					
17. FATHER'S NAME (First, Middle, Last) Milton Hyde				18. MOTHER'S NAME (First, Middle, Maiden Surname) Marie Newsinger									
19a. INFORMANT'S NAME (Type/Print) Leona L. Hyde				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4931 Mountain Rd. Pasadena, Md. 21122									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Meadowridge Cemetery		20c. LOCATION — City or Town, State Dorsey, Howard, Md.									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John D. Stief</i>				22. NAME AND ADDRESS OF FACILITY Stallings Funeral Home PA 3111 Mountain Rd. Pasadena, Md. 21122									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Colon Cancer metastatic Due to (or as a consequence of): b. To Liver and Lungs Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST										Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Mayer Gorbatsky MD</i>						29c. LICENSE NUMBER 027938			29d. DATE SIGNED (Month, Day, Year) 2/20/91				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Mayer Gorbatsky M.D. 95 Aqueduct Rd. Green Bay, WI													
31. DATE FILED (Month, Day, Year) FEB 22 1991				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>									



91 05611

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>GLADYS ALBERTA HARDEN</b>				2. DATE OF DEATH MONTH <b>02</b> DAY <b>12</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>15:23 P M</b>	
4. SOCIAL SECURITY NUMBER <b>166-36-5956</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) <b>81</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>04/28/09</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>SACRED HEART HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>CUMBERLAND, MARYLAND</b>		9c. COUNTY OF DEATH <b>ALLEGANY</b>	
10a. STATE <b>W VA</b>				10b. COUNTY <b>MINERAL</b>		10c. CITY, TOWN OR LOCATION <b>FT ASHBY</b>	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>P O BOX 524</b>			
10f. ZIP CODE <b>26719</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>LABORER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>HOTEL</b>			
17. FATHER'S NAME (First, Middle, Last) <b>JOHN C. BLOOM</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>LULU MAE STEIN</b>			
19a. INFORMANT'S NAME (Type/Print) <b>RITA M. RIVERS</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>FT ASHBY, W VA 26719</b>			
20. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>HYNDMAN CEMETERY</b>		DATE <b>2/16/91</b>		20c. LOCATION — City or Town, State <b>HYNDMAN, PA 15545</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Harvey H. Zeigler</i>				22. NAME AND ADDRESS OF FACILITY <b>HARVEY H. ZEIGLER FUNERAL HOME HYNDMAN, PA 15545-0636</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Neural failure</b> a. DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>severe heart failure</b> b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death <b>Weeks</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hepatic dysfunction metabolic acidosis</b>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>2/16/91</b>	
28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John Davidson-Randall MD</i>				29c. LICENSE NUMBER <b>1703459</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/13/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>907 SETON DRIVE CUMBERLAND, MD 21502</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 15 1991</b>				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 66760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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110 = 11

110 = 11

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05612

1. DECEDENT'S NAME (First, Middle, Last) <b>DOROTHY V. HIGGINS</b>				2. DATE OF DEATH MONTH <b>2</b> DAY <b>19</b> YEAR <b>91</b>		3. TIME OF DEATH <b>10:20 A.M.</b>					
4. SOCIAL SECURITY NUMBER <b>216-14-9266</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>79 YRS.</b>		7. DATE OF BIRTH (Month, Day, Year) <b>1/9/12</b>		8. BIRTHPLACE (State or Foreign Country) <b>MD</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>William Hill Health Care</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Cambridge</b>			9c. COUNTY OF DEATH <b>Dorchester</b>				
10a. STATE <b>MD</b>		10b. COUNTY <b>Talbot</b>		10c. CITY, TOWN OR LOCATION <b>Easton</b>			10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO				
10e. STREET AND NUMBER <b>410 Salmon Avenue</b>				10f. ZIP CODE <b>21601</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>9th</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>		15b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>							
17. FATHER'S NAME (First, Middle, Last) <b>Alonzo Bateman Smith</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Johanna Thom</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Lewis Brittingham</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>410 Salmon Avenue Easton, MD 21601</b>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Spring Hill Cemetery</b>		20c. LOCATION — City or Town, State <b>Easton, MD</b>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>JOHN R. MERCER</b>				22. NAME AND ADDRESS OF FACILITY <b>Newnam Funeral Home</b> <b>200 S. Harrison St. Easton, MD</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>a. Adenocarcinoma of the lung</b> <b>b. Adrenal metastasis</b> <b>c. Malignant Pleural Effusion</b> <b>d. Hypertension</b> <b>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> <b>Respiratory Failure</b>						Approximate Interval Between Onset and Death					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Respiratory Failure</b>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		25a. DATE OF INJURY (Month, Day, Year)		25b. TIME OF INJURY		25c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		25d. DESCRIBE HOW INJURY OCCURRED			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28b. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						29b. SIGNATURE AND TITLE OF CERTIFIER <b>Judy Charmaine Washington</b>		29c. LICENSE NUMBER <b>D31108</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/19/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Judy Charmaine Washington 302 Collins Ave. Hurlock, MD 21643</b>						31. DATE FILED (Month, Day, Year) <b>FEB 20 '91</b>					
32. REGISTRAR'S SIGNATURE <b>John F. ...</b>											



91 05613

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Bertha Louise Hardisty</b>				2. DATE OF DEATH MONTH DAY YEAR <b>February 8 1991</b>		3. TIME OF DEATH <b>12:55PM</b>	
4. SOCIAL SECURITY NUMBER <b>212-32-8400</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>57</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>7/19/33</b>	
8. BIRTHPLACE (State or Foreign Country) <b>MD</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Memorial Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Easton</b>	
9c. COUNTY OF DEATH <b>Talbot</b>				10a. STATE <b>MD</b>		10b. COUNTY <b>Caroline</b>	
10c. CITY, TOWN OR LOCATION <b>Bethlehem</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>General Delivery - Newton Road</b>	
10f. ZIP CODE <b>21609</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>12th</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Corp. Secretary</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Auto Parts Business</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Nichodemus Burnezky</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Marian Collins</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Radford W. Hardisty</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>General Delivery Bethlehem, MD 21609</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Woodlawn Mem. Cemetery 2/12</b>		20c. LOCATION — City or Town, State <b>Easton, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>JOHN R. MERCERON</b>				22. NAME AND ADDRESS OF FACILITY <b>Newnam Funeral Home 200 S. Harrison Easton, MD 21601</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Sepsis</b>							
a. DUE TO (OR AS A CONSEQUENCE OF): <b>Ovarian carcinoma</b>							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Breast cancer</b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>David H. Smith MD</b>				29c. LICENSE NUMBER <b>D35887</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/8/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>David H. Smith, MD 509 Idlewild Easton, MD 21601</b>							
31. DATE FILED (Month, Day, Year) <b>2/11/91</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED'S NAME (First, Middle, Last) <b>Mathilde I. HASHEM</b>								2. DATE OF DEATH MONTH <b>2</b> - DAY <b>17</b> - YEAR <b>91</b>				3. TIME OF DEATH <b>6:25</b> <b>PM</b>			
4. SOCIAL SECURITY NUMBER <b>216-06-3639</b>				5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>84</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>		7. DATE OF BIRTH (Month, Day, Year) <b>7-10-1906</b>		8. BIRTHPLACE (State or Foreign Country) <b>Lebanon</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Greater Laurel Beltsville Nursing Home</b>								9b. CITY, TOWN OR LOCATION OF DEATH <b>Laurel</b>				9c. COUNTY OF DEATH <b>Prince George</b>			
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Prince George</b>				10c. CITY, TOWN OR LOCATION <b>Beltsville</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER <b>13009 Ivy Drive</b>				10f. ZIP CODE <b>20705</b>				10g. CITIZEN OF WHAT COUNTRY? <b>Lebanon</b>							
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>			
15. DECEASED'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>6 years</b>				16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>				16b. KIND OF BUSINESS/INDUSTRY							
17. FATHER'S NAME (First, Middle, Last) <b>Ibrahim Hashem</b>								18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Barbara Saliby</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Habib Haddad</b>								19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>13009 Ivy Drive Beltsville, Md. 20705</b>							
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metropolitan Crematory</b>				20c. LOCATION — City or Town, State <b>Alexandria, Virginia</b>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>W B G</b>				22. NAME AND ADDRESS OF FACILITY <b>Donald V. Borgwardt Funeral home, P.A. 4400 Powder Mill Rd. Beltsville, Md. 20705</b>											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>a. Natural Causes</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. Coronary artery disease</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c. Chronic atrial fibrillation</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d. Severe Osteoarthritis</b>												Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying causes given in Part I.												24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Dr. George A. D.</b>								29c. LICENSE NUMBER <b>76743</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/18/91</b>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>4410 74th Ave Landover Hills, Md. 20784</b>															
31. DATE FILED (Month, Day, Year) <b>FEB 20 '91</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>											



91 05615

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Delmis Valgene Hogue</i>				2. DATE OF DEATH MONTH <i>2</i> DAY <i>21</i> YEAR <i>91</i>		3. TIME OF DEATH <i>3:16 P M</i>	
4. SOCIAL SECURITY NUMBER <i>180-38-9456</i>		5. SEX <i>1</i> <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>43</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>2-23-47</i>	
8. BIRTHPLACE (State or Foreign Country) <i>Pennsylvania</i>				9a. FACILITY NAME (If not institution, give street and number) <i>Holy Cross Hospital</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Silver Spring, MD</i>	
9c. COUNTY OF DEATH <i>Montgomery Co.</i>				10a. STATE <i>Maryland</i>		10b. COUNTY <i>Montgomery</i>	
10c. CITY, TOWN OR LOCATION <i>Wheaton</i>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <i>1510 Wheaton Lane</i>	
10f. ZIP CODE <i>20902</i>				10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>		11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <i>VietNam</i>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>12</i>				16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Administrative</i>		17. KIND OF BUSINESS/INDUSTRY <i>US Govt.</i>	
18. FATHER'S NAME (First, Middle, Last) <i>Clifford V. Hogue</i>				19. MOTHER'S NAME (First, Middle, Maiden Surname) <i>M. Edna Brazenski</i>			
20. INFORMANT'S NAME (Type/Print) <i>Mrs. Janice Cook</i>				21. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>241 Glen Street, Chambersburg, PA 17201</i>			
22. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				23. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Parklawn Memorial Gardens 1991 2-25</i>		24. LOCATION — City or Town, State <i>Chambersburg, PA. 17201</i>	
25. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Thomas J. [Signature]</i>				26. NAME AND ADDRESS OF FACILITY <i>Park/Grisel F.H. Chambersburg Pa.</i>			
27. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>CEREBRAL INFARCTION (CVA)</i>							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
b. <i>Ruptured CEREBRAL Aneurysm</i>							
DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
28a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
29. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				30. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
31. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				32. DATE OF INJURY (Month, Day, Year)		33. TIME OF INJURY <i>M</i>	
34. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				35. DESCRIBE HOW INJURY OCCURRED			
36. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				37. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
38. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
39. SIGNATURE AND TITLE OF CERTIFIER <i>Janice Cook M.D.</i>				40. LICENSE NUMBER <i>DO9414</i>		41. DATE SIGNED (Month, Day, Year) <i>Feb 26 91</i>	
42. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>BALAZAR E. PEREZ 10620 GA Avenue Silver Spring, MD 20902</i>							
43. DATE FILED (Month, Day, Year) <i>FEB 25 '91</i>				44. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>RALPH A. HOFFMAN</b>				2. DATE OF DEATH MONTH <b>02</b> DAY <b>17</b> YEAR <b>91</b>		3. TIME OF DEATH <b>01:15 AM</b>	
4. SOCIAL SECURITY NUMBER <b>577-50-6912</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>53</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>07 27 37</b>	
9a. FACILITY NAME (If not Institution, give street and number) <b>NORTH ARUNDEL HOSPITAL ASSOCIATION</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>GLEN BURNIE</b>		9c. COUNTY OF DEATH <b>A.A. COUNTY</b>	
10a. STATE <b>MARYLAND</b>				10b. COUNTY <b>ANNE ARUNDEL</b>		10c. CITY, TOWN OR LOCATION <b>GLEN BURNIE</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>1701 SAUNDERS WAY</b>			
10f. ZIP CODE <b>21061</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>1956-1960</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>MAINTENANCE MAN</b>		16b. KIND OF BUSINESS/INDUSTRY <b>DRUG ADDICTION RESEARCH</b>			
17. FATHER'S NAME (First, Middle, Last) <b>GEORGE H. HOFFMAN</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ELSIE M. WARNER</b>			
19a. INFORMANT'S NAME (Type/Print) <b>GREGORY E. HOFFMAN</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1701 SAUNDERS WAY-GLEN BURNIE, MD. 21061</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>METRO CREMATORY, INC.</b>		DATE <b>2/20</b>		20c. LOCATION — City or Town, State <b>CATONSVILLE, MD.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Darryl D. Kaufman</i>				22. NAME AND ADDRESS OF FACILITY <b>RAYMOND C. FINK FUNERAL HOME 21061 426 CRAIN HWY. S.W. GLEN BURNIE, MD.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>a. Metastatic Small Cell Carcinoma of Lung</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <b>N/A</b>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Marc Okun MD</i>				29c. LICENSE NUMBER <b>D28000</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/18/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MARC OKUN, M.D./203 HOSPITAL DRIVE, SUITE 206/GLEN BURNIE, MARYLAND 21061</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 19 1991</b>		32. REGISTRAR'S SIGNATURE <i>Johanna Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1837 (2) 1837

91 05617

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Richard Le Roy Iosbaker</b>				2. DATE OF DEATH MONTH <b>02</b> DAY <b>19</b> YEAR <b>91</b>		3. TIME OF DEATH <b>5:00am</b> M	
4. SOCIAL SECURITY NUMBER <b>212-30-4754</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>58</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>01/08/33</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>112 Severn Ave.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Severna Park</b>		9c. COUNTY OF DEATH <b>Anne Arundel</b>	
10a. STATE <b>MD</b>		10b. COUNTY <b>Anne Arundel</b>		10c. CITY, TOWN OR LOCATION <b>Severna Park</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>112 Severn Ave.</b>				10f. ZIP CODE <b>21146</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (13-16) <input type="checkbox"/>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Letter Carrier</b>		16b. KIND OF BUSINESS/INDUSTRY <b>U.S. Post Office</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Erwin Iosbaker</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Alma Louise Grubbs</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mrs. Dilys Ann Iosbaker</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>112 Severn Ave. Severna Park MD 21146</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metro Crematory</b>		20c. LOCATION — City or Town, State <b>Catonsville, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>495 Ritchie Hwy. Barranco Funeral Home Severna Park MD 21146</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CARCINOMA OF THE LUNG</b> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):						Approximate Interval Between Onset and Death <b>8 mo.</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD				29c. LICENSE NUMBER <b>D 7080</b>		29d. DATE SIGNED (Month, Day, Year) <b>FEB 19 1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>JOSEPH A. MEAD JR. MD 301 ST PAUL PLACE, BALTIMORE, MD 21202</b>							
31. DATE FILED <b>FEB 22 1991</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

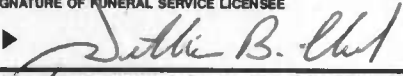
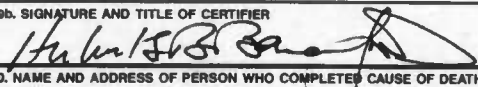
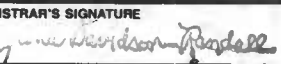




TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH				3. TIME OF DEATH	
ELIZABETH D. JONES				February 16, 1991				10:30 P M	
4. SOCIAL SECURITY NUMBER		5. SEX		6. AGE (In yrs. last birthday)		7. DATE OF BIRTH		8. BIRTHPLACE (State or Foreign Country)	
484-32-5014		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		65 YRS.		Nov 1, 1925		Alabama	
9a. FACILITY NAME (If not institution, give street and number)				9b. CITY, TOWN OR LOCATION OF DEATH				9c. COUNTY OF DEATH	
4813 Rim Rock Road				Rockville				Montgomery	
RESIDENCE OF DECEDENT									
10a. STATE		10b. COUNTY		10c. CITY, TOWN OR LOCATION		10d. INSIDE CITY LIMITS?			
Maryland		Montgomery		Rockville		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER				10f. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?			
4813 Rim Rock Road				20853		United States			
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES?		13. WAS DECEDENT OF HISPANIC ORIGIN?		14. RACE — American Indian, Black, White, etc.			
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		Specify: White			
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		IF YES, GIVE WAR OR DATES		Specify:					
15. DECEDENT'S EDUCATION (Specify only highest grade completed)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY			
Elementary/Secondary (0-12) College (1-4 or 6+)				House wife		Own Home			
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)					
Franklin O. Deese				Lilly C. Godwin					
19a. INFORMANT'S NAME (Type/Print)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)					
Megan C. Gnaill				Same as #10					
20a. METHOD OF DISPOSITION				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)		20c. LOCATION — City or Town, State			
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State				Suburban Crematory		Silver Spring, MD			
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE				22. NAME AND ADDRESS OF FACILITY					
 MO0827				Rapp Funeral Services, P.A. 933 Gist Ave, Silver Spring, MD 20910					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) →								10 months	
a. Amyotrophic Lateral Sclerosis									
DUE TO (OR AS A CONSEQUENCE OF):									
b. Adenocarcinoma of the lung (? Paraneoplastic Syndrome of ALS)								10 months	
DUE TO (OR AS A CONSEQUENCE OF):									
c. DUE TO (OR AS A CONSEQUENCE OF):									
d. DUE TO (OR AS A CONSEQUENCE OF):									
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED?	
								1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
								1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER?				26. PLACE OF DEATH (Check only one)					
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK?	
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined						M		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one)				29b. SIGNATURE AND TITLE OF CERTIFIER					
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29c. LICENSE NUMBER					
				D21924					
				29d. DATE SIGNED (Month, Day, Year)					
				Feb 17, 1991					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)									
Herbert S. B. Baraf, M.D. 10313 Georgia Ave, #107 Silver Spring, MD 20902									
31. DATE FILED (Month, Day, Year)				32. REGISTRAR'S SIGNATURE					
FEB 19 '91									



JARRETT, ROSE  
19 300604634  
BPP 301186

369

91 05619

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ROSE JARRETT</b>		2. DATE OF DEATH MONTH <b>2</b> DAY <b>17</b> YEAR <b>91</b>		3. TIME OF DEATH <b>3:18 P M</b>	
4. SOCIAL SECURITY NUMBER <b>212-16-3364</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>88</b> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <b>7-27-1902</b>		8. BIRTHPLACE (State or Foreign Country) <b>Philadelphia, Pa.</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Baltimore General Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore, Md.</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
10a. STATE <b>Md.</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Randallstown</b>	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>9109 Liberty Rd.</b>		10f. ZIP CODE <b>21133</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>	
16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Receptionist</b>		17. KIND OF BUSINESS/INDUSTRY <b>U.S. Government</b>		18. FATHER'S NAME (First, Middle, Last) <b>Abraham Jacobs</b>	
19. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Minnie Berman</b>		20. INFORMANT'S NAME (Type/Print) <b>Mildred Shankman (Niece)</b>		21. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>15101 Interlachen Dr, Silver Spring, Md. 20906</b>	
22. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		23. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>King David Memorial Garden</b>		24. LOCATION — City or Town, State <b>Falls Church, Va.</b>	
25. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Frank A. Stone</i>		26. NAME AND ADDRESS OF FACILITY <b>Danzansky-Goldberg Memorial Chapels 1170 Rockville Pike, Rockville, Md. 20852</b>		27. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Hyperosmolar Coma</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Dehydration</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF): d.  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	
28. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>multifactor dementia</b>		29a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		29b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
30. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		31. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		32. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide	
33. DATE OF INJURY (Month, Day, Year) <b>FEB 20 '91</b>		34. TIME OF INJURY <b>M</b>		35. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
36. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>2 Park Center CT Owings Mills, MD</b>		37. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>Owings Mills, MD</b>		38. DESCRIBE HOW INJURY OCCURRED	
39. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		40. SIGNATURE AND TITLE OF CERTIFIER <i>Scott R. MD</i>		41. LICENSE NUMBER <b>D13145</b>	
42. DATE SIGNED (Month, Day, Year) <b>2/19/91</b>		43. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>2 Park Center CT Owings Mills, MD</b>		44. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>	

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146



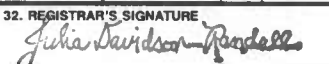
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.



91 05620

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Gertrude Avis Johnson</b>				2. DATE OF DEATH MONTH <b>2</b> DAY <b>15</b> YEAR <b>91</b>		3. TIME OF DEATH <b>4 AM</b> M	
4. SOCIAL SECURITY NUMBER <b>289-16-6136</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>81</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>10/7/09</b>	
8. BIRTHPLACE (State or Foreign Country) <b>WISCONSIN</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Holy Cross Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Silverspring Md.</b>	
9c. COUNTY OF DEATH <b>Mont.</b>							
RESIDENCE OF DECEDENT							
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>MONTGOMERY</b>		10c. CITY, TOWN OR LOCATION <b>SILVER SPRING</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>603 SLIGO AVENUE, #511</b>				10f. ZIP CODE <b>20910</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>XRAY TECHNICIAN</b>		16b. KIND OF BUSINESS/INDUSTRY <b>MEDICAL</b>			
17. FATHER'S NAME (First, Middle, Last) <b>HERBERT ANDREWS</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ALICE M. PLOMER</b>			
19a. INFORMANT'S NAME (Type/Print) <b>BEVERLY L. WESLEY (NIECE)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>#9 ROLLING GREEN ROAD, GREENVILLE, SC 29615</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>METROPOLITAN CREMATORY</b>		DATE		20c. LOCATION — City or Town, State <b>ALEXANDRIA, VIRGINIA</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W., SIL.SP., MD 20901</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Pneumonia</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>metastatic carcinoma</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide <input type="checkbox"/> Not determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D29675</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/15/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Ralph Boccia, MD 14808 PHYSICIAN Ld #212 Rockville</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 19 '91</b>		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05621

1. DECEDENT'S NAME (First, Middle, Last) <b>JAMES WALLACE JARMAN</b>						2. DATE OF DEATH MONTH DAY YEAR <b>February 19, 1991</b>		3. TIME OF DEATH <b>10:53 a m</b>		
4. SOCIAL SECURITY NUMBER <b>371-32-2520</b>		5. SEX <b>1 M 2 F</b>	6. AGE (In yrs. last birthday) <b>57 YRS.</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>57</b>		7. DATE OF BIRTH (Month, Day, Year) <b>4-12-33</b>		8. BIRTHPLACE (State or Foreign Country) <b>California</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Doctors Community Hospital</b>					9b. CITY, TOWN OR LOCATION OF DEATH <b>Lanham</b>			9c. COUNTY OF DEATH <b>Prince George's</b>		
RESIDENCE OF DECEDENT										
10a. STATE <b>MD</b>		10b. COUNTY <b>Ann Arundel</b>		10c. CITY, TOWN OR LOCATION <b>Annapolis</b>			10d. INSIDE CITY LIMITS? <b>1 YES 2 NO</b>			
10e. STREET AND NUMBER <b>15 ARBOR Hill Road</b>					10f. ZIP CODE <b>21403</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 YES 2 NO</b> IF YES, GIVE WAR OR DATES <b>1953-54</b>			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 YES 2 NO Specify:</b>			14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) _____				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Service Technician</b>			16b. KIND OF BUSINESS/INDUSTRY <b>Wells Fargo Alarm Service</b>			
17. FATHER'S NAME (First, Middle, Last) <b>John Marvin Jarman Sr.</b>					18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Dorothy Virginia Ellington</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Patricia Lee Jarman</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>15 Arbor Hill Road, Annapolis, MD</b>						
20a. METHOD OF DISPOSITION <b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) <b>Maryland Vet. Cemetery</b>			DATE <b>Crownsville, MD</b>		20c. LOCATION — City or Town, State		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>Hardesty Funeral Home, P.A. 12 Ridgely ave. Annapolis, MD</b>						
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. MYOCARDIAL INFARCTION</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>b. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO (OR AS A CONSEQUENCE OF):  c. _____ DUE TO (OR AS A CONSEQUENCE OF):  d. _____								Approximate Interval Between Onset and Death <b>minutes</b>  <b>years</b>		
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  _____						24a. WAS AN AUTOPSY PERFORMED? <b>1 YES 2 NO</b>		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1 YES 2 NO</b>		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1 YES 2 NO</b>		26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1 Inpatient 2 Outpatient 3 DOA</b> OTHER: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>								
27. MANNER OF DEATH <b>1 Natural 2 Accident 3 Suicide 4 Homicide</b> <b>5 Pending Investigation 6 Could not be determined</b>		28a. DATE OF INJURY (Month, Day, Year) <b>N/A</b>		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1 YES 2 NO</b>		28d. DESCRIBE HOW INJURY OCCURRED		
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29a. CERTIFIER (Check only one) <b>1 CERTIFYING PHYSICIAN:</b> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2 MEDICAL EXAMINER:</b> On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> Deputy Medical Examiner					29c. LICENSE NUMBER <b>201852</b>		29d. DATE SIGNED (Month, Day, Year) <b>2-19-91</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Raul A. DeVore M.D. 4203 Queensbury Rd Hyattsville MD 20781</b>										
31. DATE <b>FEB 21 1991</b>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>								

SECRET

SECRET

1. The first part of the report deals with the general situation in the country. It is noted that the economy is in a state of stagnation and that the government is facing a serious financial crisis. The report also mentions that the political situation is unstable and that there is a risk of civil unrest.

2. The second part of the report deals with the specific measures that have been taken by the government to address the economic and financial problems. It is noted that the government has implemented a series of austerity measures, including cuts in public spending and increases in taxes. It is also mentioned that the government has sought international assistance to help it cope with its financial difficulties.

3. The third part of the report deals with the social situation in the country. It is noted that there is a high level of unemployment and that many people are living in poverty. The report also mentions that there is a growing sense of disillusion and despair among the population.

4. The fourth part of the report deals with the foreign relations of the country. It is noted that the country is facing a difficult diplomatic situation and that its relations with its major trading partners are strained. The report also mentions that the country is being isolated by the international community.

5. The fifth part of the report deals with the military situation in the country. It is noted that the armed forces are in a state of disarray and that there is a risk of a military coup. The report also mentions that the government is facing a serious challenge from the opposition.

6. The sixth part of the report deals with the conclusion of the report. It is noted that the situation in the country is dire and that urgent action is needed to address the problems. The report also mentions that the author believes that the only way to save the country is to implement a series of radical reforms.

SECRET



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				91 05622					
CERTIFICATE OF DEATH				REG. NO.									
1. DECEASED'S NAME (First, Middle, Last) <b>Edna Harley Johnston</b>				2. DATE OF DEATH MONTH <b>2</b> DAY <b>16</b> YEAR <b>1991</b>				3. TIME OF DEATH <b>3 :40P M</b>					
4. SOCIAL SECURITY NUMBER <b>124-26-3033</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>85</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) <b>June 1, 1905</b>		8. BIRTHPLACE (State or Foreign Country) <b>New York N.Y.</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Memorial Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Easton</b>				9c. COUNTY OF DEATH <b>Talbot</b>					
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Talbot</b>		10c. CITY, TOWN OR LOCATION <b>St. Michaels</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER <b>San Domingo Farm</b>				10f. ZIP CODE <b>21663</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>12</b> Elementary/Secondary (0-12) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>				16b. KIND OF BUSINESS/INDUSTRY <b>None</b>							
17. FATHER'S NAME (First, Middle, Last) <b>William J. Harley</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Catherine Harley</b>									
19a. INFORMANT'S NAME (Type/Print) <b>Frances J. Huntman</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>San Domingo Farm St. Michaels, Maryland 21663</b>									
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>San Domingo Farm Cemetery Feb. 18, 1991</b>		DATE <b>Feb. 18, 1991</b>		20c. LOCATION — City or Town, State <b>St. Michaels Md.</b>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Harrison E. Leonard</b>				22. NAME AND ADDRESS OF FACILITY <b>Harrison E. Leonard Funeral Home 21663 312 S. Talbot St. St. Michaels, Maryland</b>									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>Metastatic breast cancer</b> <b>1-3 yrs</b> <b>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> <b>Severe atherosclerotic coronary artery and cerebrovascular disease</b>								Approximate Interval Between Onset and Death <b>1-3 yrs</b>					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Severe atherosclerotic coronary artery and cerebrovascular disease</b>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Lawrence D. Bohan M.D.</b>				29c. LICENSE NUMBER <b>D 27401</b>				29d. DATE SIGNED (Month, Day, Year) <b>2-16-91</b>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Lawrence D. Bohan M.D. 606 Dutchmans Lane Easton, Maryland 21601</b>													
31. DATE FILED (Month, Day, Year) <b>FEB 19 1991</b>				32. REGISTRAR'S SIGNATURE <b>Johnston</b>									



1. FOR STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE		9105623	
1 - STATE REGISTRAR		CERTIFICATE OF DEATH		REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last) BARBARA ANN JOHNSON				2. DATE OF DEATH FEB. 16, 1991	
3. TIME OF DEATH 10:25 P.M.		4. SOCIAL SECURITY NUMBER 505-38-1362		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	
6. AGE (In yrs. last birthday) 54 YRS.		7. DATE OF BIRTH (Month, Day, Year) 3-20-1936		8. BIRTHPLACE (State or Foreign Country) SOUTH DAKOTA	
9a. FACILITY NAME (If not institution, give street and number) 103 MAPLE AVENUE		9b. CITY, TOWN OR LOCATION OF DEATH PRESTON		9c. COUNTY OF DEATH CAROLINE	
10a. STATE MARYLAND		10b. COUNTY CAROLINE		10c. CITY, TOWN OR LOCATION PRESTON	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 103 MAPLE AVENUE		10f. ZIP CODE 21655	
10g. CITIZEN OF WHAT COUNTRY? U.S.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CLERICAL SUPERVISOR		16b. KIND OF BUSINESS/INDUSTRY HOSPITAL RADIOLOGY DEPT.		17. FATHER'S NAME (First, Middle, Last) TOBIAS BUEHNER	
18. MOTHER'S NAME (First, Middle, Maiden Surname) MARTHA RINAS		19a. INFORMANT'S NAME (Type/Print) ROBERT L. JOHNSON		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 103 MAPLE AVE. PRESTON, MD. 21655	
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) MD. VETERANS CEMETERY-E.S. HURLOCK, MARYLAND		20c. LOCATION — City or Town, State MD. VETERANS CEMETERY-E.S. HURLOCK, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE JOHN R. MERCERON		22. NAME AND ADDRESS OF FACILITY NEWMAN FUNERAL HOME 200 S. HARRISON ST. EASTON, MD. 21601		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CARDIAC ARREST DUE TO (OR AS A CONSEQUENCE OF): b. TOTAL BODY INJURY DUE TO (OR AS A CONSEQUENCE OF): c. METASTATIC OVARIAN CARCINOMA DUE TO (OR AS A CONSEQUENCE OF): d. SEQUENTIALLY LIST CONDITIONS, IF ANY, LEADING TO IMMEDIATE CAUSE. ENTER UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER L. BRADLEY BAKER, M.D.	
29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) 2-18-91		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) L. BRADLEY BAKER, M.D. 609 BUTCHMAN'S LANE EASTON, MD. 21601	
31. DATE FILED (Month, Day, Year) FEB 19 1991		32. REGISTRAR'S SIGNATURE John R. Mercer		33. DATE OF DEATH FEB. 16, 1991	



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				91 05624			
CERTIFICATE OF DEATH				REG. NO.							
1. DECEDENT'S NAME (First, Middle, Last) Nellie Forbes Kellogg				2. DATE OF DEATH MONTH DAY YEAR 02 15 91				3. TIME OF DEATH 11:25 P.M.			
4. SOCIAL SECURITY NUMBER 216-46-2803		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 91 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov. 21, 1899		8. BIRTHPLACE (State or Foreign Country) Elizabeth, N.C.			
9a. FACILITY NAME (If not institution, give street and number) Frederick Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Frederick				9c. COUNTY OF DEATH Frederick			
10a. STATE md		10b. COUNTY Frederick		10c. CITY, TOWN OR LOCATION Frederick				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER 8102 Artie Kemp Rd.				10f. ZIP CODE 21701				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker				16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) William Forbes				18. MOTHER'S NAME (First, Middle, Maiden Surname) Nannie Martha Dozier							
19a. INFORMANT'S NAME (Type/Print) John F. Kellogg (Son)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6140 West Donnagail Dr. Penn Laird, VA. 22846							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Ft. Lincoln Cemetery				20c. LOCATION — City or Town, State Brentwood, MD.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Vernon J. Simmons				22. NAME AND ADDRESS OF FACILITY Joseph Gawler's Sons Inc. 5130 Wisconsin Ave. Wash. D.C. 20016 N.W.							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → A. S. C. V. D. (Arteriosclerotic Cardiovascular Disease)								Approximate Interval Between Onset and Death 10 Yr			
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER Julia Davidson-Randall				29c. LICENSE NUMBER D-31912		29d. DATE SIGNED (Month, Day, Year) 02/16/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Julio Menocal, 516 Trail Ave - Frederick, MD 21701											
31. DATE FILED (Month, Day, Year) FEB 19 '91				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall							



91 05625

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) John I. Keating				2. DATE OF DEATH MONTH DAY YEAR Feb, 14, 1991		3. TIME OF DEATH 9:30 A M	
4. SOCIAL SECURITY NUMBER 116-26-1450		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 89 YRS.		7. DATE OF BIRTH (Month, Day, Year) Feb. 18, 1901	
8. BIRTHPLACE (State or Foreign Country) New York				9a. FACILITY NAME (If not Institution, give street and number) Greenbelt Nursing Center		9b. CITY, TOWN OR LOCATION OF DEATH Greenbelt	
9c. COUNTY OF DEATH Prince George's				10a. STATE VA.		10b. COUNTY Loudon	
10c. CITY, TOWN OR LOCATION Lovettsville				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER Route 2 Box 245	
10f. ZIP CODE 22080				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 6+) 8				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Policeman		16b. KIND OF BUSINESS/INDUSTRY New York Police Dept.	
17. FATHER'S NAME (First, Middle, Last) James Keating				18. MOTHER'S NAME (First, Middle, Maiden Surname) Bridget Gaughran			
19a. INFORMANT'S NAME (Type/Print) Sheila Kryston				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Route 2, Box 245, Lovettsville, VA. 22080			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Mount Confort Crematory		20c. LOCATION — City or Town, State Alex. VA.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Kernow</i>				22. NAME AND ADDRESS OF FACILITY Joseph Gawler's Sons Inc. 5130 Wisconsin Ave. N.W. Wasg D.C. 20016			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → ASLD (Arteriosclerotic Cardiovascular Disease) DUE TO (OR AS A CONSEQUENCE OF): CORPD DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST						Approximate Interval Between Onset and Death 11 yr 2 20 yr 8	
PART II. Other significant condition contributing to death but not resulting in the underlying cause given in Part I. CHRONIC ANEMIA						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John I. Keating</i>				29c. LICENSE NUMBER D20391		29d. DATE SIGNED (Month, Day, Year) 2/14/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BET BURKH REH HARTMAN MD							
31. DATE FILED (Month, Day, Year) FEB 19 91				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				91 05626			
CERTIFICATE OF DEATH				REG. NO.							
1. DECEASED'S NAME (First, Middle, Last) Hazel Magdeline Kelly				2. DATE OF DEATH MONTH DAY YEAR 02 01 91				3. TIME OF DEATH 6:52 pm			
4. SOCIAL SECURITY NUMBER 579-09-0948		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 88 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jan. 22, 1903		8. BIRTHPLACE (State or Foreign Country) Washington, DC			
9a. FACILITY NAME (If not institution, give street and number) Leland Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Riverdale				9c. COUNTY OF DEATH Prince George's			
10a. STATE MD.		10b. COUNTY Prince George		10c. CITY, TOWN OR LOCATION Hyattsville				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER 3404 Toledo Terrace #A				10f. ZIP CODE 20782				10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: Black			
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (13-16 or 17+)		16. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Sales Clerk				17. KIND OF BUSINESS/INDUSTRY Federal Government					
17. FATHER'S NAME (First, Middle, Last) William Thomas				18. MOTHER'S NAME (First, Middle, Maiden Surname) Rose Thomas							
19a. INFORMANT'S NAME (Type/Print) Hilda Kelly				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8750 Georgia Avenue Silver Spring, Md. 20910							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Lincoln Memorial Cemetery				20c. LOCATION — City or Town, State Suitland, Md.					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶				22. NAME AND ADDRESS OF FACILITY R. N. Horton Co. 600 Kennedy St., N. W.							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Intra Cerebral Hemorrhage DUE TO (OR AS A CONSEQUENCE OF): b. Accelerated hypertension DUE TO (OR AS A CONSEQUENCE OF): c. Untreated hypertension DUE TO (OR AS A CONSEQUENCE OF): d. Atherosclerosis Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) NA		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED NA		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) NA		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) NA							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER S. K. K. K. K. K.						29c. LICENSE NUMBER D21200		29d. DATE SIGNED (Month, Day, Year) 2-2-1991			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SHRINIVAS R. UDAPATI 7245 Hanover Pkway, Greenbelt, MD 20770.											
31. DATE FILED (Month, Day, Year) FEB 19 '91				32. REGISTRAR'S SIGNATURE John Davidson-Randall							



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH				3. TIME OF DEATH			
Dorothy Clagett King				February 16, 1991				5:00 am M			
4. SOCIAL SECURITY NUMBER		5. SEX		6. AGE (in yrs. birthday)		7. DATE OF BIRTH		8. BIRTHPLACE (State or Foreign Country)			
220-44-8875		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		88 YRS.		Aug. 18, 1902		Maryland			
9a. FACILITY NAME (If not institution, give street and number)				9b. CITY, TOWN OR LOCATION OF DEATH				9c. COUNTY OF DEATH			
Carriage Hill Bethesda				Bethesda				Montgomery			
RESIDENCE OF DECEDENT											
10a. STATE		10b. COUNTY		10c. CITY, TOWN OR LOCATION		10d. INSIDE CITY LIMITS?					
Maryland		Montgomery		Bethesda		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER				10f. ZIP CODE				10g. CITIZEN OF WHAT COUNTRY?			
4324 Rosedale Avenue				20814				U.S.A.			
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES?		13. WAS DECEDENT OF HISPANIC ORIGIN?		14. RACE — American Indian, Black, White, etc.					
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed)				16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				17. KIND OF BUSINESS/INDUSTRY			
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				Secretary				U.S. Department of the Treasury			
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)							
Joseph Lee Clagett				Grace Collins							
19a. INFORMANT'S NAME (Type/Print)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)							
Mary C. Carter				4501 West Virginia Avenue, Bethesda, Maryland 20814							
20a. METHOD OF DISPOSITION		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)		20c. LOCATION — City or Town, State							
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		Saint Mary's Cemetery		Rockville, Maryland							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE				22. NAME AND ADDRESS OF FACILITY							
<i>George T. Boppre</i> M00335				Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Avenue Bethesda, Maryland 20814 Wisconsin							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death			
IMMEDIATE CAUSE (Final disease or condition resulting in death) →								1 hour			
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								10 yrs			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED?		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
<i>Arterio-sclerotic cerebrovascular disease</i>								1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER?				26. PLACE OF DEATH (Check only one)							
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK?		28d. DESCRIBE HOW INJURY OCCURRED	
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined						M		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
29a. CERTIFIER (Check only one)				29b. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				29c. LICENSE NUMBER			
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								DD 2421			
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29d. DATE SIGNED (Month, Day, Year)			
29e. SIGNATURE AND TITLE OF CERTIFIER								16 Feb 91			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)											
Paul T. Noone, M.D., 50 W. Edmonston Drive # 207 Rockville, Maryland 20852											
31. DATE FILED (Month, Day, Year)				32. REGISTRAR'S SIGNATURE							
FEB 19 '91				<i>John Davidson</i>							



91 05628

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Virginia Marie Kueny				2. DATE OF DEATH MONTH 2 DAY 11 YEAR 1991		3. TIME OF DEATH 6:00		A			
4. SOCIAL SECURITY NUMBER 370-68-2975		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 83 YRS.		7. DATE OF BIRTH (Month, Day, Year) 10-16-1907		8. BIRTHPLACE (State or Foreign Country) Michigan			
9a. FACILITY NAME (If not institution, give street and number) Villa Rosa Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Mitchellville		9c. COUNTY OF DEATH Prince George					
10a. STATE Va.		10b. COUNTY		10c. CITY, TOWN OR LOCATION Alexandria		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
10e. STREET AND NUMBER 2302 Kimbrough Street				10f. ZIP CODE 22307		10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 1/12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY ---							
17. FATHER'S NAME (First, Middle, Last) John Klinkner				18. MOTHER'S NAME (First, Middle, Maiden Surname) Elmira Couture							
19a. INFORMANT'S NAME (Type/Print) Virginia Richardson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2302 Kimbrough Street Alex. Va. 22307							
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place) Everyday Crematory		DATE		20c. LOCATION — City or Town, State Fairfax, Va.					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>McKenna-Louis Groat</i>				22. NAME AND ADDRESS OF FACILITY HINES/RINALDI FUNERAL HOME 11800 New Hamp. Ave. S.S. Md.							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Cerebral Hypoxia arrest</i> DUE TO (OR AS A CONSEQUENCE OF):  b. <i>Myocardial infarct</i> DUE TO (OR AS A CONSEQUENCE OF):  c. <i>Alcoholism</i> DUE TO (OR AS A CONSEQUENCE OF):  d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		26. PLACE OF DEATH (Check only one) OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Julia Davidson</i>				29c. LICENSE NUMBER B 14156		29d. DATE SIGNED (Month, Day, Year) 11-11-91					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 3308 Dado PK Rd Bethesda MD 20785											
31. DATE FILED (Month, Day, Year) FEB 15 '91				32. REGISTRAR'S SIGNATURE <i>Julia Davidson</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Page 1 of 1  
Date: 10/10/10  
Time: 10:10:10  
User: admin

Page 2 of 2

Page 3 of 3

Page 4 of 4

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05629

1. DECEDENT'S NAME (First, Middle, Last) Evan Kays				2. DATE OF DEATH MONTH 02 DAY 19 YEAR 91		3. TIME OF DEATH 2:30 PM				
4. SOCIAL SECURITY NUMBER 117-30-0388		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 64 YRS.		7. DATE OF BIRTH (Month, Day, Year) 02/13/27		8. BIRTHPLACE (State or Foreign Country) Greece		
9a. FACILITY NAME (If not institution, give street and number) 854 Swift Road				9b. CITY, TOWN OR LOCATION OF DEATH Pasadena			9c. COUNTY OF DEATH Anne Arundel			
10a. STATE MD		10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Glen Burnie			10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 901 Dorking Road				10f. ZIP CODE 21063		10g. CITIZEN OF WHAT COUNTRY? U.S.A.				
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Caucasian				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12+ College (13-16) 5+				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Self Employed		16b. KIND OF BUSINESS/INDUSTRY Paint Company				
17. FATHER'S NAME (First, Middle, Last) Theodore Kays				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ellen						
19a. INFORMANT'S NAME (Type/Print) Miss. Marina Kays				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 854 Swift Road Pasadena MD 21122						
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Greek Orthod. Cemete		20c. LOCATION — City or Town, State Baltimore, Maryland						
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James E. Barranco</i>				22. NAME AND ADDRESS OF FACILITY 495 Ritchie Hwy. Barranco Funeral Home Severna Park MD 21146						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiorespiratory arrest DUE TO (OR AS A CONSEQUENCE OF): b. Carcinoma Right upper lobe DUE TO (OR AS A CONSEQUENCE OF): c. Metastases liver, stomach, bones etc DUE TO (OR AS A CONSEQUENCE OF): d. Recent myocardial infarction Approximate Interval Between Onset and Death 8/1989							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. COPD, cachexia, azotemia etc.										
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Nick P. Mountsoos MD</i>		29c. LICENSE NUMBER D08801		29d. DATE SIGNED (Month, Day, Year) 2/20/91		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) NICK P. MOUNTSOOS MD, 95 AQUAHART RD, GLEN BURNIE MD, 21061										
31. DATE FILED (Month, Day, Year) FEB 22 1991				32. REGISTRAR'S SIGNATURE <i>John Davidson</i>						





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, and 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05630

1. DECEASED'S NAME (First, Middle, Last) Katharine M. Killen				2. DATE OF DEATH MONTH 2 DAY 4 YEAR 91		3. TIME OF DEATH 1:25 a m			
4. SOCIAL SECURITY NUMBER 264-54-8655		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 84 YRS.		7. DATE OF BIRTH (Month, Day, Year) 10/13/06		8. BIRTHPLACE (State or Foreign Country) GA	
9a. FACILITY NAME (If not institution, give street and number) Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Easton			9c. COUNTY OF DEATH Talbot		
10a. STATE MD			10b. COUNTY Talbot		10c. CITY, TOWN OR LOCATION Easton			10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 724 Mecklenburg Avenue				10f. ZIP CODE 21601		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 3			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Nurse			16b. KIND OF BUSINESS/INDUSTRY Hospital			
17. FATHER'S NAME (First, Middle, Last) Monroe Arnold				18. MOTHER'S NAME (First, Middle, Maiden Surname) Pearl Haygood					
19a. INFORMANT'S NAME (Type/Print) Evelyn F. Gates				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 724 Mecklenburg Ave. Easton, MD 21601					
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Richardson Family Cem. 2/6		DATE Cambridge, MD		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE JOHN R. MERCER				22. NAME AND ADDRESS OF FACILITY Newnam Funeral Home 200 S. Harrison Easton, MD 21601					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. DIABETIC COMA DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):						Approximate Interval Between Onset and Death 11/5/91			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PNEUMONIA CEREBROVASCULAR INSUFFICIENCY						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER C.W. Rain MD				29c. LICENSE NUMBER D00250		29d. DATE SIGNED (Month, Day, Year) 2/4/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) C.W. RAIN, 415 E. DOVER, EASTON, MD, 21601									
31. DATE FILED (Month, Day, Year) FEB - 6 '91				32. REGISTRAR'S SIGNATURE John R. Mercer					

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Mildred Tunis Kemp</b>				2. DATE OF DEATH MONTH DAY YEAR <b>February 18 1991</b>		3. TIME OF DEATH <b>9:00AM</b>	
4. SOCIAL SECURITY NUMBER <b>216-40-2698</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) <b>97</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Dec. 18, 1893</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Memorial Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Easton</b>				9c. COUNTY OF DEATH <b>Talbot</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Talbot</b>		10c. CITY, TOWN OR LOCATION <b>McDaniel</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>Mallard Point</b>				10f. ZIP CODE <b>P.O. Box 71 21647</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>1</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife Inn Keeper</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Boarding House</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Henry Clay Tunis</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Viola White</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Jane K. Christianson</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. Box 71 McDaniel, Maryland 21647</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Spring Hill Cemetery</b>		20c. LOCATION — City or Town, State <b>2-21-91 Easton, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Harrison E. Leonard</i>				22. NAME AND ADDRESS OF FACILITY <b>Harrison E. Leonard Funeral Home 21663 312 S. Talbot St. St. Michaels, Maryland</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Atherosclerotic Cardiovascular disease</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>b. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>c. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>d. RECENT ANTERIOR MYOCARDIAL INFARCTION</b>						Approximate Interval Between Onset and Death <b>1 month</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Advanced old age, RECENT occipital LOBE CVA</b>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide					
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Ludwig J. Eglstetter II MD</i>				29c. LICENSE NUMBER <b>MD D 31466</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/18/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Ludwig J. Eglstetter II MD 606 Dutchman's Lane MD 21601</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 19 '91</b>				32. REGISTRAR'S SIGNATURE <i>Julian Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				91 05632			
1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH				3. TIME OF DEATH			
Ronald Richard KEADLE, Sr.				2 19 91				1050 M			
4. SOCIAL SECURITY NUMBER		5. SEX		6. AGE (In yrs. last birthday)		7. DATE OF BIRTH		8. BIRTHPLACE (State or Foreign Country)			
214-28-7410		1 M 2 F		58 YRS.		Aug. 17, 1932		Maryland			
9a. FACILITY NAME (If not institution, give street and number)				9b. CITY, TOWN OR LOCATION OF DEATH				9c. COUNTY OF DEATH			
Frederick Memorial Hospital				Frederick				Frederick			
RESIDENCE OF DECEDENT											
10a. STATE		10b. COUNTY		10c. CITY, TOWN OR LOCATION		10d. INSIDE CITY LIMITS?					
Maryland		Washington		Boonsboro		1 YES 2 NO					
10e. STREET AND NUMBER				10f. ZIP CODE				10g. CITIZEN OF WHAT COUNTRY?			
21432 Greenbriar Road				21713				USA			
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES?		13. WAS DECEDENT OF HISPANIC ORIGIN?		14. RACE — American Indian, Black, White, etc.					
1 Never Married 2 Married 3 Widowed 4 Divorced		1 YES 2 NO IF YES, GIVE WAR OR DATES Korean		1 YES 2 NO Specify:		Specify: white					
15. DECEDENT'S EDUCATION (Specify only highest grade completed)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY			
Elementary/Secondary (0-12) 11 College (14 or 5+) 0				superintendent				bridge construction			
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)							
Guy E. Keadle				Ethel Stottlemeyer							
19a. INFORMANT'S NAME (Type/Print)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)							
Guy E. Keadle				21432 Greenbriar Rd., Boonsboro, Md. 21713							
20a. METHOD OF DISPOSITION		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)		20c. LOCATION — City or Town, State							
1 Burial 2X Cremation 3 Removal from State 4 Donation 5 Other (Specify)		Smithsburg Crematory		Smithsburg, Maryland							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE				22. NAME AND ADDRESS OF FACILITY							
Scott M. Minnich				MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death			
IMMEDIATE CAUSE (Final disease or condition resulting in death) →											
a. Cardiorespiratory Arrest											
b. Terminal metastatic urinary bladder carcinoma											
c. DUE TO (OR AS A CONSEQUENCE OF):											
d. DUE TO (OR AS A CONSEQUENCE OF):											
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED?		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
Renal Failure								1 YES 2X NO		1 YES 2 NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER?				26. PLACE OF DEATH (Check only one)							
1 YES 2X NO				HOSPITAL: 1X Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)							
27. MANNER OF DEATH		28a. DATE OF INJURY		28b. TIME OF INJURY		28c. INJURY AT WORK?		28d. DESCRIBE HOW INJURY OCCURRED			
1X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined		(Month, Day, Year)		M		1 YES 2 NO					
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one)				29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year)	
1X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				William B. Mondak...				D-18191		2-19-91	
2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)											
ANTHONY G. MARANO, M.D. 187 Thom John Dr. Frederick, MD 21702											
31. DATE FILED (Month, Day, Year)				32. REGISTRAR'S SIGNATURE							
FEB 20 '91				Julia Davidson-Randall							



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				CERTIFICATE OF DEATH				REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last) <b>Hilda Mae Kindall</b>				2. DATE OF DEATH MONTH <b>02</b> - DAY <b>19</b> - YEAR <b>91</b>				3. TIME OF DEATH <b>0320 am</b>							
4. SOCIAL SECURITY NUMBER <b>214-09-4548</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>69</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) <b>4-26-21</b>		8. BIRTHPLACE (State or Foreign Country) <b>MD</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Washington County Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Hagerstown</b>				9c. COUNTY OF DEATH <b>Washington</b>							
10a. STATE <b>MD</b>		10b. COUNTY <b>Washington</b>		10c. CITY, TOWN OR LOCATION <b>Hagerstown</b>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER <b>112 Elm St.</b>				10f. ZIP CODE <b>21740</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Seamstress</b>				16b. KIND OF BUSINESS/INDUSTRY <b>E.J. Fennel</b>							
17. FATHER'S NAME (First, Middle, Last) <b>Jesse Shank</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Anne Rowe</b>											
19a. INFORMANT'S NAME (Type/Print) <b>Karol Sumpter</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>26 Belview Ave. Hagerstown, MD 21740</b>											
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Smithsburg Crematory</b>		20c. LOCATION — City or Town, State <b>Smithsburg, MD</b>											
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Rennis R. Davis</b>				22. NAME AND ADDRESS OF FACILITY <b>Davis Funeral Home Rt. 3 Box 78 Smithsburg, MD 21783</b>											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Vasculitis unknown type</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes mellitus Type II, Dementia, Hypertension, Diabetes, Atherosclerosis</b>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED							
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28t. LOCATION (Street and Number or Rural Route Number, City or Town, State)											
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <b>[Signature]</b>				29c. LICENSE NUMBER <b>D26806</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/19/91</b>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Alan W. Dillman 1610 Oak Hill Ave Hagerstown MD 21740</b>															
31. DATE FILED (Month, Day, Year) <b>FEB 21 '91</b>				32. REGISTRAR'S SIGNATURE <b>Juha Davidson-Randall</b>											

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05634

1. DECEDENT'S NAME (First, Middle, Last) Cleifton L. Keefer Cleifton Leroy Keefer				2. DATE OF DEATH MONTH DAY YEAR February 19th 1991		3. TIME OF DEATH 1151 AM	
4. SOCIAL SECURITY NUMBER 217-36-4025		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 66 YRS.		7. DATE OF BIRTH (Month, Day, Year) 10/8/24	
9a. FACILITY NAME (If not institution, give street and number) Frederick Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Frederick		9c. COUNTY OF DEATH Frederick	
10a. STATE Maryland				10b. COUNTY Frederick		10c. CITY, TOWN OR LOCATION Mt. Airy	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 10638 Old National Pike				10f. ZIP CODE 21771		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) farmer		16b. KIND OF BUSINESS/INDUSTRY dairy	
17. FATHER'S NAME (First, Middle, Last) Glenn S. Keefer				18. MOTHER'S NAME (First, Middle, Maiden Surname) Alma Treasia Bond			
19a. INFORMANT'S NAME (Type/Print) William F. Keefer				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11401 Keymar Rd. Woodsboro, MD 21798			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Methodist Cemetery		20c. LOCATION — City or Town, State Johnsville, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Catherine O. Hartzler</i>				22. NAME AND ADDRESS OF FACILITY D.D. Hartzler & Sons Union Bridge, MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → acute myocardial infarction & arrest Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Generalized arteriosclerosis PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Insulin dependent Diabetes Mellitus							Approximate Interval Between Onset and Death
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Ronald E. Miller</i>				29c. LICENSE NUMBER 026499		29d. DATE SIGNED (Month, Day, Year) 2/19/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Ronald E. Miller 4 Culwell Dr. Mt. Airy, MD 21771							
31. DATE FILED (Month, Day, Year) FEB 21 '91				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				91 05635			
CERTIFICATE OF DEATH				REG. NO.							
1. DECEDENT'S NAME (First, Middle, Last) <b>MARGARET I. KOCHIS</b>				2. DATE OF DEATH MONTH DAY YEAR <b>February 15, 1991</b>				3. TIME OF DEATH <b>10:17P M</b>			
4. SOCIAL SECURITY NUMBER <b>215-74-8394</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>80</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) <b>01-06-1911</b>		8. BIRTHPLACE (State or Foreign Country) <b>PA</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Memorial Hospital &amp; Medical Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Cumberland</b>				9c. COUNTY OF DEATH <b>Allegany</b>			
RESIDENCE OF DECEDENT											
10a. STATE <b>MD</b>		10b. COUNTY <b>Allegany</b>		10c. CITY, TOWN OR LOCATION <b>Cresaptown,</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER <b>13502 McMullen Highway</b>				10f. ZIP CODE <b>21502</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>housewife</b>		16b. KIND OF BUSINESS/INDUSTRY <b>own home</b>					
17. FATHER'S NAME (First, Middle, Last) <b>John Kopper</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary (nmn)</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Mr. John M. Kochis, Sr.</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>13502 McMullen Highway Cresaptown, MD 21502</b>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>St. Ambrose Cemetery</b>				20c. LOCATION — City or Town, State <b>Cresaptown, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>James F. Scarpelli</b>				22. NAME AND ADDRESS OF FACILITY <b>Scarpelli Funeral Home Cumberland, MD 21502</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>MI</b> <b>CHF</b> <b>St. bleed</b> <b>resp failure</b>										Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) →											
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <b>Dr. Poonai</b>				29c. LICENSE NUMBER <b>D36766</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/18/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Poonai 955 Frederick Street, Cumberland, MD 21502</b>											
31. DATE FILED (Month, Day, Year) <b>FEB 19 1991</b>				32. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>							



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				CERTIFICATE OF DEATH				REG. NO.							
1. DECEDENT'S NAME (First, Middle, Last) J. Arthur Lazell								2. DATE OF DEATH MONTH DAY YEAR February 17, 1991				3. TIME OF DEATH 12:25P M							
4. SOCIAL SECURITY NUMBER 071-20-8587				5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 79 YRS.		7. DATE OF BIRTH (Month, Day, Year) Feb. 8, 1912		8. BIRTHPLACE (State or Foreign Country) New York									
9a. FACILITY NAME (If not institution, give street and number) Circle Manor Nursing Home								9b. CITY, TOWN OR LOCATION OF DEATH Kensington				9c. COUNTY OF DEATH Montgomery							
10a. STATE Maryland				10b. COUNTY Montgomery				10c. CITY, TOWN OR LOCATION Kensington				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 9641 E. Bexhill Drive								10f. ZIP CODE 20895				10g. CITIZEN OF WHAT COUNTRY? United States							
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) —				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Assistant Director				16b. KIND OF BUSINESS/INDUSTRY Bureau of Radiological Health											
17. FATHER'S NAME (First, Middle, Last) Joseph A. Lazell								18. MOTHER'S NAME (First, Middle, Maiden Surname) Hazel Agnes Ellis											
19a. INFORMANT'S NAME (Type/Print) Christa M. Lazell								19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9641 E. Bexhill Drive, Kensington, MD 20895											
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Montgomery Crematorium 2/18/91				20c. LOCATION — City or Town, State Bethesda, Maryland											
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Richard P. Hutto</i> M00348								22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave., Bethesda, MD. 20814-3501											
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Operation Pneumonia</i> DUE TO (OR AS A CONSEQUENCE OF):  b. <i>Parkinsons Disease</i> DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d. DUE TO (OR AS A CONSEQUENCE OF):  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST												Approximate Interval Between Onset and Death <i>2 wks</i> <i>YEAR</i>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)															
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M				28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)								28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)											
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>J.P.H.</i>								29c. LICENSE NUMBER D34032				29d. DATE SIGNED (Month, Day, Year) 2/17/91							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JEANNE P. ASHER 3720 FARRAGUT AVE, KENSINGTON, MD 20895																			
31. DATE FILED (Month, Day, Year) FEB 19 '91				32. REGISTRAR'S SIGNATURE <i>Juha Davidson-Randall</i>															



91 05637

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>FLORENCE RIMER LEAS</b>		2. DATE OF DEATH MONTH <b>2</b> - DAY <b>12</b> - YEAR <b>91</b>		3. TIME OF DEATH <b>1:35 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>578-46-6590</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>89</b> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <b>8/23/01</b>		8. BIRTHPLACE (State or Foreign Country) <b>PENNSYLVANIA</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>HOLY CROSS HOSPITAL</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>SILVER SPRING</b>		9c. COUNTY OF DEATH <b>MONTGOMERY</b>	
10a. STATE <b>MD</b>		10b. COUNTY <b>MONTGOMERY</b>		10c. CITY, TOWN OR LOCATION <b>SILVER SPRING</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>3613 BEACHTREE CT.</b>		10f. ZIP CODE <b>20906</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOMEMAKER</b>		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <b>HENRY RIMER</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MINNIE PROPP</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MARY L. SMITH (DAUGHTER)</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8812 34th AVENUE, COLLEGE PARK, MARYLAND 20740</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>ARLINGTON NATIONAL CEMETERY</b>		20c. LOCATION — City or Town, State <b>ARLINGTON, VIRGINIA</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>		22. NAME AND ADDRESS OF FACILITY <b>FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W., SIL.SP., MD 20901</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CARDIO PULMONARY ARREST</b> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <b>GASTROINTESTINAL BLEED</b> c. <b>POSSIBLE SEPSIS</b>					Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)	
28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD		29c. LICENSE NUMBER <b>D-33224</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/12/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>RAM TRETAN 11119 Rockville Pike # 208, Rockville MD 20852</b>					
31. DATE FILED (Month, Day, Year) <b>FEB 14 '91</b>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, and 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05638

1. DECEDENT'S NAME (First, Middle, Last) <b>CAROL J. LASWELL</b>				2. DATE OF DEATH MONTH <b>2</b> - DAY <b>11</b> - YEAR <b>91</b>		3. TIME OF DEATH <b>12:22 P.</b>					
4. SOCIAL SECURITY NUMBER <b>324-304306</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (in yrs. last birthday) <b>55</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>01-06-36</b>		8. BIRTHPLACE (State or Foreign Country) <b>ILLINOIS</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Howard County General Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Columbia</b>				9c. COUNTY OF DEATH <b>Howard</b>			
10a. STATE <b>MD.</b>		10b. COUNTY <b>HOWARD</b>		10c. CITY, TOWN OR LOCATION <b>WEST FRIENDSHIP</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER <b>3455 RTE. 32, E. IVORY ROAD</b>				10f. ZIP CODE <b>21794</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>COMPUTER OPERATOR</b>			16b. KIND OF BUSINESS/INDUSTRY <b>COMPUTER COMPANY</b>				
17. FATHER'S NAME (First, Middle, Last) <b>ROBERT J. HAENIG</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>VERA MAE ALTIG</b>							
19a. INFORMANT'S NAME (Type/Print) <b>HAROLD W. LASWELL (HUSBAND)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3455 RTE. 32, E. IVORY ROAD, W. FRIENDSHIP, MARYLAND 21794</b>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>COLUMBIA MEMORIAL PARK</b>			20c. LOCATION — City or Town, State <b>COLUMBIA, MARYLAND</b>						
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W. SIL. SP., MD 20901</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> a. <b>End stage cardiac failure</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Congestive cardiomyopathy</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>Renal insufficiency</b> DUE TO (OR AS A CONSEQUENCE OF): d. <b>Diabetes mellitus</b>								Approximate interval Between Onset and Death			
24. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Sarcoidosis</b>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Lynn D. Alonso MD</i>						29c. LICENSE NUMBER <b>D32482 MD</b>		29d. DATE SIGNED (Month, Day, Year) <b>2-11-91</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>LYNN D. ALONSO, MD. TWO KNOLL NORTH DR, COLUMBIA, MD 21045</b>											
31. DATE FILED (Month, Day, Year) <b>FEB 14 '91</b>				32. REGISTRAR'S SIGNATURE <i>Johanna Davidson-Randall</i>							

*Handwritten signature*

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				CERTIFICATE OF DEATH				REG. NO.					
1. DECEDENT'S NAME (First, Middle, Last) Connie Lett						2. DATE OF DEATH MONTH DAY YEAR Feb. 15, 1991				3. TIME OF DEATH M							
4. SOCIAL SECURITY NUMBER 416-06-1275		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 27 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) 3-14-63		8. BIRTHPLACE (State or Foreign Country) La.					
9a. FACILITY NAME (If not institution, give street and number) 1806 Walker Drive						9b. CITY, TOWN OR LOCATION OF DEATH Ft. Meade				9c. COUNTY OF DEATH A.A. Co.							
10a. STATE Md		10b. COUNTY A.A. Co.		10c. CITY, TOWN OR LOCATION Ft. Meade				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO									
10e. STREET AND NUMBER 1806 Walker Drive						10f. ZIP CODE 20755		10g. CITIZEN OF WHAT COUNTRY? USA									
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White									
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Clerk				16b. KIND OF BUSINESS/INDUSTRY									
17. FATHER'S NAME (First, Middle, Last) Virgil Sears						18. MOTHER'S NAME (First, Middle, Maiden Surname) Sarah Rakestran											
19a. INFORMANT'S NAME (Type/Print) Robert G. Lett						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1806 Walker Drive Ft. Meade Md 20755											
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Reese Grove Baptist				20c. LOCATION — City or Town, State Ashville Alabama											
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ball</i>						22. NAME AND ADDRESS OF FACILITY Hardesty Funeral Home 851 Annapolis Rd Gambrills Md 21054											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory Failure DUE TO (OR AS A CONSEQUENCE OF): b. Acute Myelogenous Leukemia DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST										Approximate Interval Between Onset and Death 2 wks 10 months							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)															
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED									
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)													
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												29b. SIGNATURE AND TITLE OF CERTIFIER <i>Ross</i>		29c. LICENSE NUMBER US Army		29d. DATE SIGNED (Month, Day, Year) 16 Feb 91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)																	
31. DATE FILED (Month, Day, Year) FEB 19 1991				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>													



91 05640

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Gustav F. Luttringhaus				2. DATE OF DEATH MONTH 02/12/91 YEAR		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER 145-09-7905		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 89 YRS.		7. DATE OF BIRTH MONTH 07/18/01	
9a. FACILITY NAME (If not institution, give street and number) 24 Truckhouse Road		9b. CITY, TOWN OR LOCATION OF DEATH S.P. Merridean N.H.		9c. COUNTY OF DEATH Anne Arundel			
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Arnold		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 750 Locust Circle				10f. ZIP CODE 21012		10g. CITIZEN OR WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Caucasian	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12+ College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Retired Chemist		16b. KIND OF BUSINESS/INDUSTRY G.A.F. Corp.			
17. FATHER'S NAME (First, Middle, Last) Walter Luttringhaus				18. MOTHER'S NAME (First, Middle, Maiden Surname) Philipina Zagorniak			
19a. INFORMANT'S NAME (Type/Print) Mr. Robert H. Koster				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1731 Fillmoore Court Crofton MD 21114			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Meadowridge Mem. Pk.		20c. LOCATION — City or Town, State Dorsey, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James E. Barranco</i>		22. NAME AND ADDRESS OF FACILITY Barranco Funeral Home Severna Park MD 21146					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Ca of Pro state = metast SPRUE - C4 quadriplegia Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED					
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Michael J. Latenta</i>				29c. LICENSE NUMBER D 21438		29d. DATE SIGNED (Month, Day, Year) 2/15/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MICHAEL J. LATENTA MD 600 RIDGLEY AVE, HAZO, ANNAPOLIS MD							
31. DATE FILED (Month, Day, Year) FEB 19 1991		32. REGISTRAR'S SIGNATURE <i>Johia Davidson-Rendell</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.




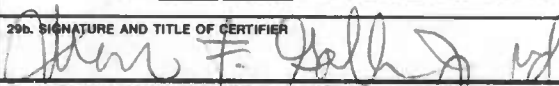
ITEMS:23 thru 28f per ME  
G-673 3/22/91 cm

91 05641

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Diane J. Larner</b>				2. DATE OF DEATH MONTH DAY YEAR <b>02 14 91</b>		3. TIME OF DEATH <b>8.00 A M</b>	
4. SOCIAL SECURITY NUMBER <b>215-50-1680</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>38 YRS.</b>		7. DATE OF BIRTH (Month, Day, Year) <b>10-5-1952</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Wisconsin</b>				9a. FACILITY NAME (If not institution, give street and number) <b>116 Groh Lane</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Annapolis</b>	
9c. COUNTY OF DEATH <b>Anne Arundel</b>				10a. STATE <b>Md.</b>		10b. COUNTY <b>Anne Arundel</b>	
10c. CITY, TOWN OR LOCATION <b>Annapolis</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>116 Groh Lane</b>	
10f. ZIP CODE <b>21403</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+) <b>2</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Home</b>	
17. FATHER'S NAME (First, Middle, Last) <b>David Fauley</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Jenine C. Jacobson</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Marshall P. Larner</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>116 Groh Lane Annapolis, Md. 21403</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>St Anne's Cemetery 2-18</b>		20c. LOCATION — City or Town, State <b>Annapolis, Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Taylor Funeral Chapel Annapolis, Md.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ACUTE AND CHRONIC SUBDURAL HEMORRHAGE</b>							
a. DUE TO (OR AS A CONSEQUENCE OF):							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) <b>FOUND: 2/14/91</b>			
28b. TIME OF INJURY <b>M</b>				28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED <b>UNKNOWN</b>				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>116 GROH LANE ANNAPOLIS, AA CO., MARYLAND</b>			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>02-14-91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MARIO F. GOLIE JR. MD 111 PENN ST. BALTO MD 21201</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 19 1991</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BOB B. MORRIS BOB

NOTICE

1991 10 18 17



DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) <b>ALICE ELIZABETH LUM</b>				2. DATE OF DEATH MONTH DAY YEAR <b>Feb. 22 1997</b>		3. TIME OF DEATH M <b>M</b>				
4. SOCIAL SECURITY NUMBER <b>216-30-3631</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>56</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>July 2, 1934</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>		
9a. FACILITY NAME (If not institution, give street and number) <b>Washington County Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Hagerstown</b>			9c. COUNTY OF DEATH <b>Washington</b>			
10a. STATE <b>MD</b>		10b. COUNTY <b>Washington</b>		10c. CITY, TOWN OR LOCATION <b>Smithsburg</b>			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER <b>Rt. 4 Box 219</b>				10f. ZIP CODE <b>21783</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) College (1-4 or 5 +)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Nursing Aide</b>			16b. KIND OF BUSINESS/INDUSTRY <b>Nursing Home</b>					
17. FATHER'S NAME (First, Middle, Last) <b>Calvert C. Stottlemeyer</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Maude L. Eccard</b>						
19a. INFORMANT'S NAME (Type/Print) <b>Gary N. Lum</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Rt. 4 Box 219 Smithsburg, MD 21783</b>						
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Cedar Lawn Memorial Park</b>		20c. LOCATION — City or Town, State <b>Hagerstown, MD</b>						
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>Davis Funeral Home Rt. 3 Box 78 Smithsburg, MD 21783</b>						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Respiratory Failure</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Chronic obstructive pulmonary Disease</b> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Ischemic Heart Disease</b>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>						29c. LICENSE NUMBER <b>D21457</b>		29d. DATE SIGNED (Month, Day, Year) <b>FEB 25 1997</b>		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>ABOU WATHEED, MD - 1610 - OAK HILL AVE. HAGERSTOWN, MD</b>										
31. DATE FILED (Month, Day, Year) <b>FEB 25 '97</b>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>								



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05643

1. DECEDENT'S NAME (First, Middle, Last) <b>FRED William Lucas</b>				2. DATE OF DEATH MONTH <b>Feb</b> DAY <b>19</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>9:00 AM</b>					
4. SOCIAL SECURITY NUMBER <b>213-38-9514</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>49</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>2/22/1941</b>		8. BIRTHPLACE (State or Foreign Country) <b>Pennsylvania</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Glen Falls Road</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Reisterstown</b>			9c. COUNTY OF DEATH <b>Baltimore</b>				
RESIDENCE OF DECEDENT											
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Carroll</b>		10c. CITY, TOWN OR LOCATION <b>Reisterstown</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER <b>2521 Hollingsworth Road</b>				10f. ZIP CODE <b>21136</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>1959-1963</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Accountant</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Accounting</b>							
17. FATHER'S NAME (First, Middle, Last) <b>Glenn Thomas Lucas</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>LaRue Naomi Schaeffer</b>							
19a. INFORMANT'S NAME (Type/Print) <b>A. Susan Lucas</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2521 Hollingsworth Road, Reisterstown, MD</b>							
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Carroll Crematory</b>		20c. LOCATION — City or Town, State <b>Hampstead, Maryland</b>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Susan Lucas</i>		22. NAME AND ADDRESS OF FACILITY <b>Myers Funeral Home</b> <b>91 Willis Street, Westminster, MD</b>									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. shotgun wound of head</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. Depression</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c.</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death <b>9 months</b>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Work</b>		26. PLACE OF DEATH (Check only one)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>Feb 19, 1991</b>		28b. TIME OF INJURY <b>9:00 AM</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED <b>Shotgun</b>			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>Work</b>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>Glen Falls Rd</b>							
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Stanley Z. Fe/Jan 1991</i> Deputy Medical Examiner		29c. LICENSE NUMBER <b>201680</b>		29d. DATE SIGNED (Month, Day, Year) <b>Feb 19, 1991</b>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Stanley Z. Fe/Jan 1991 MD I.E. Chase JR 220</b>											
31. DATE FILED (Month, Day, Year) <b>FEB 21 '91</b>		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>									



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05644

1. DECEDENT'S NAME (First, Middle, Last) RUSSELL CASHMAN LAMBERT				2. DATE OF DEATH MONTH DAY YEAR Feb. 20, 1991		3. TIME OF DEATH 12:20PM M	
4. SOCIAL SECURITY NUMBER 218-32-4520		5. SEX 1 <input checked="" type="checkbox"/> MALE 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 84 YRS.		7. DATE OF BIRTH (Month, Day, Year) 01/01/07	
8. BIRTHPLACE (State or Foreign Country) MARYLAND		9a. FACILITY NAME (If not institution, give street and number) 401 CHURCH ST.		9b. CITY, TOWN OR LOCATION OF DEATH NEW WINDSOR		9c. COUNTY OF DEATH CARROLL	
10a. STATE MD		10b. COUNTY CARROLL		10c. CITY, TOWN OR LOCATION NEW WINDSOR		10d. INSIDE CITY LIMITS 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 401 CHURCH ST.		10f. ZIP CODE 21776		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES NO		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO NO		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) OWNER-OPERATOR		16b. KIND OF BUSINESS/INDUSTRY GARAGE			
17. FATHER'S NAME (First, Middle, Last) ARTHUR S. LAMBERT				18. MOTHER'S NAME (First, Middle, Maiden Surname) NELLIE CASHMAN			
19a. INFORMANT'S NAME (Type/Print) RUTHANNA B. LAMBERT				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 401 CHURCH ST. NEW WINDSOR MD 21776			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) WINTERS CEMETERY		20c. LOCATION — City or Town, State NR. NEW WINDSOR, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Catherine O. Shultzler</i>				22. NAME AND ADDRESS OF FACILITY D. D. HARTZLER & SONS NEW WINDSOR, MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Acute cardio-respiratory failure</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>chronic congestive heart failure</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>ASCVD</i> DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death <i>years</i> <i>years</i>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>post coronary artery bypass</i> <i>malignant leiomyosarcoma</i> <i>metastasis to liver</i>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Ephraim Barzaga</i>				29c. LICENSE NUMBER <i>D14992</i>		29d. DATE SIGNED (Month, Day, Year) <i>2-21-91</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>EPHRAIM BARZAGA - NEW WINDSOR, MD. 21776</i>							
31. DATE FILED (Month, Day, Year) <i>FEB 21 91</i>				32. REGISTRAR'S SIGNATURE <i>Jane Davidson-Randall</i>			



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05645

1. DECEASED'S NAME (First, Middle, Last) ELIZABETH McGOWN				2. DATE OF DEATH MONTH DAY YEAR FEB 14 1991				3. TIME OF DEATH 5 AM	
4. SOCIAL SECURITY NUMBER 577-42-9990		6. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 84 YRS.		7. DATE OF BIRTH (Month, Day, Year) 11-10-1906		8. BIRTHPLACE (State or Foreign Country) SCOTLAND	
9a. FACILITY NAME (If not institution, give street and number) 10704 MONTGOMERY ROAD				9b. CITY, TOWN OR LOCATION OF DEATH BELTSVILLE				9c. COUNTY OF DEATH PRINCE GEORGE'S	
10a. STATE MARYLAND		10b. COUNTY PRINCE GEORGE'S		10c. CITY, TOWN OR LOCATION BELTSVILLE				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 10704 MONTGOMERY ROAD				10f. ZIP CODE 20705		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 13 College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER				16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) UNKNOWN ALCORN				18. MOTHER'S NAME (First, Middle, Maiden Surname) UNKNOWN					
19a. INFORMANT'S NAME (Type/Print) JOHN R. MCGOWN, JR. (SON)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10704 MONTGOMERY ROAD BELTSVILLE, MARYLAND 20705					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) GEORGE WASHINGTON CEMETERY ADELPHI, MARYLAND				20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Michael J. Butler				22. NAME AND ADDRESS OF FACILITY FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W. SIL. SPR., MD. 20901					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Severe chronic obstructive lung disease DUE TO (OR AS A CONSEQUENCE OF): b. Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal failure								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Pragya B. Patel MD Internal Medicine		29c. LICENSE NUMBER D24095		29d. DATE SIGNED (Month, Day, Year) 2-15-91			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) PRAGYA B. PATEL MD. 5632 Annapolis Rd #11 Bladensburg MD. 20710									
31. DATE FILED (Month, Day, Year) 2-15 FEB 19 91				32. REGISTRAR'S SIGNATURE John Davidson-Randall					





TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05646

1. DECEDENT'S NAME (First, Middle, Last) <b>Robert S. MYERS</b>		2. DATE OF DEATH MONTH <b>2</b> DAY <b>15</b> YEAR <b>91</b>		3. TIME OF DEATH <b>7:10 a. m.</b>	
4. SOCIAL SECURITY NUMBER <b>577-03-7843</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>84</b> YRS.	
7. DATE OF BIRTH MONTH <b>10</b> DAY <b>5</b> YEAR <b>06</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>		9. COUNTY OF DEATH <b>HOWARD</b>	
10a. FACILITY NAME (If not institution, give street and number) <b>7296 Sanner Road</b>		10b. CITY, TOWN OR LOCATION OF DEATH <b>Clarksville</b>		10c. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WWII</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11th</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Messenger</b>	
17. FATHER'S NAME (First, Middle, Last) <b>John W. Myers</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Elizabeth Smith</b>		19. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7296 Sanner Road, Clarksville, MD 21029</b>	
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Locust Cemetery</b>		20c. LOCATION — City or Town, State <b>Simpsonville, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Gorge R. Snowden</b>		22. NAME AND ADDRESS OF FACILITY <b>SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850</b>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Metastatic Prostate Cancer</b>  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. <b>Metastatic Prostate Cancer</b> DUE TO (OR AS A CONSEQUENCE OF):  b. DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d. DUE TO (OR AS A CONSEQUENCE OF):  Approximate Interval Between Onset and Death <b>Years</b> <b>Years</b>	
24. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Homicide	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>M. Choi M.D.</b>		29c. LICENSE NUMBER <b>D35799</b>	
29d. DATE SIGNED (Month, Day, Year) <b>2-15-91</b>		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>M. Choi, M.D., 2 Knoll North Drive, Columbia, MD 21045</b>		31. DATE FILED (Month, Day, Year) <b>FEB 19 '91</b>	
32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>					



DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				REG. NO.	
1 - FOR STATE REGISTRAR				CERTIFICATE OF DEATH	
1. DECEDENT'S NAME (First, Middle, Last) <b>ANDREW MOTAYNE</b>			2. DATE OF DEATH MONTH <b>2</b> DAY <b>14</b> YEAR <b>91</b>		3. TIME OF DEATH <b>11:45 P.M.</b>
4. SOCIAL SECURITY NUMBER <b>217-94-9451</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>82</b> YRS.		7. DATE OF BIRTH (Month/Day/Year) <b>11/30/08</b>
8. FACILITY NAME (If not institution, give street and number) <b>Holy Cross Hospital</b>			9b. CITY, TOWN OR LOCATION OF DEATH <b>Silver Spring, Md.</b>		9c. COUNTY OF DEATH <b>MONTGOMERY</b>
10a. STATE <b>Md.</b>			10b. COUNTY <b>MONTGOMERY</b>		10c. CITY, TOWN OR LOCATION OF DEATH <b>Silver Spring</b>
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			10e. STREET AND NUMBER <b>8500 16th St. #125</b>		
10f. ZIP CODE <b>20998</b>			10g. CITIZEN OF WHAT COUNTRY? <b>GUYANA</b>		
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: <b>ASIAN</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>RET. - TAILOR</b>		16b. KIND OF BUSINESS/INDUSTRY <b>CLOTHING</b>			
17. FATHER'S NAME (First, Middle, Last) <b>EDWARD MOTAYNE</b>			18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ELVIRA BHOLA</b>		
19a. INFORMANT'S NAME (Type/Print) <b>PAULETTE MOTAYNE</b>			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3705 S. GEROGE MASON DR., FALLS CHURCH, VA. 22041</b>		
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) <b>GATE OF HEAVEN CEMETERY 2/19/91</b>		20c. LOCATION — City or Town, State <b>SILVER SPRING, MD.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>W.W. Chambers</b> MO0091			22. NAME AND ADDRESS OF FACILITY <b>W. W. CHAMBERS CO., RIVERDALE, MD. 20737</b>		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>PROSTATE CANCER w/ METASTASIS</b> <b>SEPSIS</b> <b>UREMIA</b> <b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> <b>UREMIA</b>					Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) <input checked="" type="checkbox"/> HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <b>J. P. [Signature]</b>			29c. LICENSE NUMBER <b>D37002</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/15/91</b>
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>JEAN WELSH M.D. HOLY CROSS HOSPT, SILVER SPRING, Md.</b>					
31. DATE FILED (Month, Day, Year) <b>FEB 19 '91</b>		32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Rodell</b>			

RIGHT 124 BOUND

208-61104

91 05648

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>THEODORE W. MILES</b> <i>THEODORE, WILLIAM MILES</i>				2. DATE OF DEATH MONTH DAY YEAR <b>FEBRUARY 18, 1991</b>		3. TIME OF DEATH <b>8:50A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>579-40-2509</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>72</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>APRIL 17, 1918</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>HOLY CROSS HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>SILVER SPRING</b>		9c. COUNTY OF DEATH <b>MONTGOMERY</b>	
10a. STATE <b>MARYLAND</b>				10b. COUNTY <b>MONTGOMERY</b>		10c. CITY, TOWN OR LOCATION <b>SILVER SPRING</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO							
10e. STREET AND NUMBER <b>3701 WOODRIDGE AVENUE</b>				10f. ZIP CODE <b>20902</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>2</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>COST ANALYST</b>		16b. KIND OF BUSINESS/INDUSTRY <b>CIVIL AERONAUTICAL BOARD</b>			
17. FATHER'S NAME (First, Middle, Last) <b>CHARLES W. MILES</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>PEARL E. INSCOE</b>			
19a. INFORMANT'S NAME (Type/Print) <b>FLORENA B. MILES (WIFE)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3701 WOODRIDGE AVENUE, SILVER SPRING, MARYLAND 20902</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>METROPOLITAN CREMATORY</b>		20c. LOCATION — City or Town, State <b>ALEXANDRIA, VIRGINIA</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael J. Bigner</i>				22. NAME AND ADDRESS OF FACILITY <b>FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W., SIL.SP., MD 20901</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acute Myeloblastic Leukemia</b> DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death: <b>4 DAYS</b> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>J. H. M.</i>		29c. LICENSE NUMBER <b>D32407</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/18/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>JOSEPH HAGGERTY MD 14808 PHYSICIANS LANE SUITE 212 ROCKVILLE MD 20850</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 19 '91</b>		32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				CERTIFICATE OF DEATH				REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last) <b>Twila Beverly Martin</b>								2. DATE OF DEATH MONTH DAY YEAR <b>2-15-91</b>				3. TIME OF DEATH <b>5:05 P.M.</b>			
4. SOCIAL SECURITY NUMBER				5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		5. AGE (In yrs. last birthday) <b>79</b> YRS.		6. UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) <b>March 14 1912</b>		8. BIRTHPLACE (State or Foreign Country) <b>Penna</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Holy Cross Hospital</b>								9b. CITY, TOWN OR LOCATION OF DEATH <b>Silver Spring</b>				9c. COUNTY OF DEATH <b>Montgomery</b>			
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Montgomery</b>				10c. CITY, TOWN OR LOCATION <b>Silver Spring</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER <b>2313 Hildarose Street</b>								10f. ZIP CODE				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>12</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>				16b. KIND OF BUSINESS/INDUSTRY <b>At Home</b>							
17. FATHER'S NAME (First, Middle, Last) <b>Cort Hess</b>								18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Iva Hoover</b>							
19a. INFORMANT'S NAME (Type/Print) <b>John S. Martin, Jr.</b>								19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>536 Wilson Pl. Frederick, MD., 21702</b>							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Salem United Meth.Ch. Cem.</b>				20c. LOCATION — City or Town, State <b>Wolfsville, MD.</b>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>KENDALL BURNLEY VANCIL</b> <i>Kendall Burnley Vancil</i>								22. NAME AND ADDRESS OF FACILITY <b>TAKOMA FUNERAL HOME, INC</b> <b>254 Carroll St. N.W. Washington DC</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiac arrhythmia</b>  Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <div style="display: flex; align-items: center;"> <div style="font-size: 3em; margin-right: 10px;">{</div> <div> <p>a. <b>Coronary artery Disease</b> DUE TO (OR AS A CONSEQUENCE OF):</p> <p>b.  DUE TO (OR AS A CONSEQUENCE OF):</p> <p>c.  DUE TO (OR AS A CONSEQUENCE OF):</p> <p>d.  DUE TO (OR AS A CONSEQUENCE OF):</p> </div> </div>												Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA				OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				26. PLACE OF DEATH (Check only one)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Undetermined				28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M				28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John S. Martin Jr.</i>								29c. LICENSE NUMBER <b>PO8546</b>				29d. DATE SIGNED (Month, Day, Year) <b>2-15-91</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>John S. Martin Jr. 8218 Wilson</b>															
31. DATE FILED (Month, Day, Year) <b>FEB 20 '91</b>				32. REGISTRAR'S SIGNATURE <i>John Davidson</i>											





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, & 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

91 05650

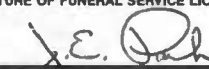
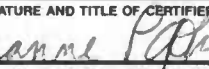
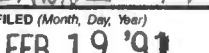
1. DECEDENT'S NAME (First, Middle, Last) <b>FLORENCE K. McKenna</b>		2. DATE OF DEATH MONTH DAY YEAR <b>February 15, 1991</b>		3. TIME OF DEATH <b>8:00 p m</b>	
4. SOCIAL SECURITY NUMBER <b>579-09-2525</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>84 YRS.</b>	
7. DATE OF BIRTH (Month, Day, Year) <b>9/15/06</b>		8. BIRTHPLACE (State or Foreign Country) <b>Pennsylvania</b>		9. COUNTY OF DEATH <b>Montgomery</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Circle Manor Nursing Home</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Kensington MD</b>		9c. COUNTY OF DEATH <b>Montgomery</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Kensington</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>3703 Calvert Place</b>		10f. ZIP CODE <b>20895</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>College (14 or 5+)</b> <b>2</b>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Security Analyst FDIC</b>		16b. KIND OF BUSINESS/INDUSTRY		17. FATHER'S NAME (First, Middle, Last) <b>William James McKenna</b>	
18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mayne Enright</b>		19a. INFORMANT'S NAME (Type/Print) <b>Mary M. McKenna</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3703 Calvert Place Kensington, Maryland 20895</b>	
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Gate of Heaven Cemetery</b>		20c. LOCATION — City or Town, State <b>Silver Spring, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Francis J. Collins</i>		22. NAME AND ADDRESS OF FACILITY <b>Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., Md. 20901</b>		23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. aspiration pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. Alzheimer's dementia</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c.</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b>  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Nomicide <input type="checkbox"/> Could not be determined	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Jeanne P. Asner</i>		29c. LICENSE NUMBER <b>034032</b>	
29d. DATE SIGNED (Month, Day, Year) <b>2/16/91</b>		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>JEANNE P. ASNER 3720 PARRAGUT AVE KENSINGTON MD 20895</b>		31. DATE FILED (Month, Day, Year) <b>FEB 19 '91</b>	
32. REGISTRAR'S SIGNATURE <i>John Davidson-Randell</i>					



1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>VIRGINIA PANGLE MATTHEWS</b>		2. DATE OF DEATH MONTH DAY YEAR <b>FEB 18, 1991</b>		3. TIME OF DEATH <b>8:45 A M</b>	
4. SOCIAL SECURITY NUMBER <b>224-10-8816</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>88</b> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <b>Nov 22, 1902</b>		8. BIRTHPLACE (State or Foreign Country) <b>Virginia</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Randolph Hills Nursing Home</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Wheaton</b>		9c. COUNTY OF DEATH <b>Montgomery</b>	
RESIDENCE OF DECEDENT					
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Silver Spring</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER <b>10511 Bucknell Dr.</b>		10f. ZIP CODE <b>20902</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>2</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Office Manager</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Public Assistance Assoc.</b>	
17. FATHER'S NAME (First, Middle, Last) <b>James Madison Pangle</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Lena Davis Guard</b>			
19a. INFORMANT'S NAME (Type/Print) <b>William N. Graber</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11810 Grandview Ave. Wheaton, MD 20902</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Greenhill Cemetery 2/21/91</b>		20c. LOCATION — City or Town, State <b>Stephen City, VA</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  <b>MO0896</b>		22. NAME AND ADDRESS OF FACILITY <b>DeVol Funeral Home 10 E. Deer Park Dr. Gaithersburg, MD 20877</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) →  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		a. <b>Aspiration Pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF):  b. <b>Bladder cancer</b> DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d. DUE TO (OR AS A CONSEQUENCE OF):		Approximate interval Between Onset and Death <b>1 month</b> <b>6 months</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.     		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER  <b>JEANNE P. ASHER</b>		29c. LICENSE NUMBER <b>D34032</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/18/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>JEANNE P. ASHER 3720 FARRAGUT AVE KENSINGTON MD 20895</b>					
31. DATE FILED (Month, Day, Year) <b>FEB 19 '91</b>		32. REGISTRAR'S SIGNATURE 			



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05652

1. DECEDENT'S NAME (First, Middle, Last) <b>RONALD R MCINTOSH</b>				2. DATE OF DEATH MONTH <b>2</b> DAY <b>13</b> YEAR <b>91</b>		3. TIME OF DEATH <b>P</b> <b>M</b>					
4. SOCIAL SECURITY NUMBER <b>170-30-1159</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>52</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>8 3 38</b>		8. BIRTHPLACE (State or Foreign Country) <b>Pennsylvania</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>18036 COTTAGE GARDEN DR</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>GERMANTOWN</b>				9c. COUNTY OF DEATH <b>MONTGOMERY</b>			
10a. STATE <b>Virginia</b>		10b. COUNTY <b>Loudoun</b>		10c. CITY, TOWN OR LOCATION <b>Sterling</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER <b>21034 Thoreau Court</b>				10f. ZIP CODE <b>22170</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>1956-1960</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>-</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Maintenance Supervisor</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Apartment Complex</b>					
17. FATHER'S NAME (First, Middle, Last) <b>Charles Henry McIntosh</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Dorothy Miller</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Carol A. McIntosh</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5670 Stevens Forest Road, #106 Columbia, MD 21045</b>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Forest Lawn Cemetery</b>		20c. LOCATION — City or Town, State <b>Johnstown, Pennsylvania</b>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Michael E. Perry</b> M00803				22. NAME AND ADDRESS OF FACILITY <b>Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ASPHYXIA - HANGING</b> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):								Approximate Interval Between Onset and Death <b>ACUTE</b>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ALCOHOLISM</b>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) <b>2 13 91</b>		28b. TIME OF INJURY <b>P</b> <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED <b>ROPE IN METER ROOM</b>	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>Home</b>				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>18036 COTTAGE GARDEN DR</b>							
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <b>[Signature]</b>						29c. LICENSE NUMBER <b>D07099</b>		29d. DATE SIGNED (Month, Day, Year) <b>2-16-91</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>FRANCIS C MYLE 2208 WISCONSIN AVE BETHESDA MD 20814/3120</b>											
31. DATE FILED (Month, Day, Year) <b>FEB 19 '91</b>				32. REGISTRAR'S SIGNATURE <b>[Signature]</b>							



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				91 05653					
CERTIFICATE OF DEATH				REG. NO.									
1. DECEDENT'S NAME (First, Middle, Last) Robert Macy				2. DATE OF DEATH MONTH DAY YEAR Feb. 13, 1991				3. TIME OF DEATH 7:30 A M					
4. SOCIAL SECURITY NUMBER 091-14-1454		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Mar. 17, 1908		8. BIRTHPLACE (State or Foreign Country) Iowa	
9a. FACILITY NAME (If not institution, give street and number) Bethesda Retirement Center				9b. CITY, TOWN OR LOCATION OF DEATH Chevy Chase				9c. COUNTY OF DEATH Montgomery					
10a. STATE ---		10b. COUNTY ---		10c. CITY, TOWN OR LOCATION Washington, D.C.				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO					
10e. STREET AND NUMBER 4829 Loughboro Road, N.W.				10f. ZIP CODE 20016				10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Economist				16b. KIND OF BUSINESS/INDUSTRY U.S. Gov't.							
17. FATHER'S NAME (First, Middle, Last) Clarence Macy				18. MOTHER'S NAME (First, Middle, Maiden Surname) Madge Young									
19a. INFORMANT'S NAME (Type/Print) Deborah K. Macy				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4829 Loughboro Rd., NW, Washington, D.C. 20016									
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Comfort Crematory				20c. LOCATION — City or Town, State Alexandria, VA							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael Nelson</i>				22. NAME AND ADDRESS OF FACILITY Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave, NW, Washington, D.C. 20016									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) →  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. Congestive heart failure DUE TO (OR AS A CONSEQUENCE OF): Mitral valve disease b. Cerebral vascular disease DUE TO (OR AS A CONSEQUENCE OF): c. d.								Approximate Interval Between Onset and Death 5 yrs. 30+ yrs. 2+ yrs.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cyanosis ; Weight loss								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>David R. Lawrenz</i>				29c. LICENSE NUMBER 3314		29d. DATE SIGNED (Month, Day, Year) Feb. 13, 1991			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) David R. Lawrenz, M.D., 1145-19th St., NW, Washington, D.C. 20036													
31. DATE FILED (Month, Day, Year) FEB 15 '91				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>									





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2 & 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05654

1. DECEDENT'S NAME (First, Middle, Last) <b>Catherine Wilhemina MADDEN</b>				2. DATE OF DEATH MONTH DAY YEAR <b>16 February 1991</b>		3. TIME OF DEATH <b>8:47 A M</b>					
4. SOCIAL SECURITY NUMBER <b>220-46-5409</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>78</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>4-28-1912</b>		8. BIRTHPLACE (State or Foreign Country) <b>Kinderhook, N.Y.</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Doctors' Community Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Lanham</b>				9c. COUNTY OF DEATH <b>Prince George's</b>			
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Prince George</b>		10c. CITY, TOWN OR LOCATION <b>Greenbelt</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER <b>149 Westway Road T-2</b>				10f. ZIP CODE <b>20770</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>12 years</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY							
17. FATHER'S NAME (First, Middle, Last) <b>George W. Tracey</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Frances Jane Hickey</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Martin G. Madden</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11524 Crows Nest Road Clarksville, Md. 21029</b>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Gate of Heaven Cemetery 2/19/90 Silver Spring, Maryland</b>		20c. LOCATION — City or Town, State							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>W.B. G...</b>				22. NAME AND ADDRESS OF FACILITY <b>Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Md. 20705</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Immediate Cause (Final disease or condition resulting in death) →</b> <b>Acute respiratory failure</b> <b>Due to (or as a consequence of):</b> <b>pneumonia</b> <b>Severe chronic obstructive lung disease</b> <b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b>								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <input type="checkbox"/> YES <input type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>T. CHA NOLLEN, M.D.</b>		29c. LICENSE NUMBER <b>D/3339</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/16/91</b>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>T. CHA NOLLEN, M.D. 8824 Cunningham Dr. Beverly Hills, Md.</b>				31. DATE FILED (Month, Day, Year) <b>FEB 20 '91</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Rendell</b>			



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				91 05655					
CERTIFICATE OF DEATH				REG. NO.									
1. DECEDENT'S NAME (First, Middle, Last) Florence Elizabeth Murphy						2. DATE OF DEATH MONTH DAY YEAR 2-20-1991		3. TIME OF DEATH M					
4. SOCIAL SECURITY NUMBER 214 05 0299		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 98 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH MONTH DAY YEAR 11/16/1893		8. BIRTHPLACE (State or Foreign Country) MARYLAND					
9a. FACILITY NAME (If not institution, give street and number) ANNE ARUNDEL MED. CTR						9b. CITY, TOWN OR LOCATION OF DEATH ANNAPOLIS			9c. COUNTY OF DEATH ANNE ARUNDEL				
10a. STATE MD.						10b. COUNTY ANNE ARUNDEL		10c. CITY, TOWN OR LOCATION 1918 THOMAS DR ANNAPOLIS		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 1918 THOMAS DR				10f. ZIP CODE 21401		10g. CITIZEN OF WHAT COUNTRY? USA							
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (14 or S+) —				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER		16b. KIND OF BUSINESS/INDUSTRY HOUSE							
17. FATHER'S NAME (First, Middle, Last) GEORGE CLEMENT WOOD						18. MOTHER'S NAME (First, Middle, Maiden Surname) FLORENCE JANE ELLIOTT							
19a. INFORMANT'S NAME (Type/Print) FRANK G. BAKER JR				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 COVE OF CORK LA ANNAPOLIS MD 21401									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) CEDAR BLUFF Cem.		20c. LOCATION — City or Town, State ANNAPOLIS MD									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Charles E. Berger				22. NAME AND ADDRESS OF FACILITY TAYLOR FUNERAL CHAPEL 147 GLOUCESTER ST. ANNAPOLIS MD 21401									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Sudden Cardiac Death DUE TO (OR AS A CONSEQUENCE OF): b. Coronary Artery Disease DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST										Approximate Interval Between Onset and Death Instantly years			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia - Confusion										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residencia 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										29c. LICENSE NUMBER D11653		29d. DATE SIGNED (Month, Day, Year) 2/21/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) PETER F. VERKOUW M.D. 1833 Forest Dr. Annapolis, Md. 21401													
31. DATE FILED (Month, Day, Year) FEB 22 1991				32. REGISTRAR'S SIGNATURE John Davidson-Rendell									



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05656

1. DECEDENT'S NAME (First, Middle, Last) <b>THORNTON WILLIAM MEANS, Jr.</b>		2. DATE OF DEATH MONTH DAY YEAR <b>FEBRUARY 10, 1991</b>		3. TIME OF DEATH <b>10:05 AM</b>	
4. SOCIAL SECURITY NUMBER <b>214 07 4868</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>74</b> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <b>OCT. 28, 1916</b>		8. BIRTHPLACE (State or Foreign Country) <b>MD</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>SACRED HEART HOSPITAL</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>CUMBERLAND</b>		9c. COUNTY OF DEATH <b>ALLEGANY</b>	
10a. STATE <b>MD</b>		10b. COUNTY <b>Allegany</b>		10c. CITY, TOWN OR LOCATION <b>Cumberland</b>	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>Gowden Drive</b>		10f. ZIP CODE <b>21502</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW II</b>	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>--</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Liaison Officer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>US Government</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Thornton W. Means, Sr.</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Elizabeth (Smith)</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Betty D. Means</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P. O. BOX 518, Cumberland, MD 21502</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Hillcrest Burial Park 2/12/91</b>		20c. LOCATION — City or Town, State <b>Cumberland, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>William J. Kuyt</b>		22. NAME AND ADDRESS OF FACILITY <b>Kight Funeral Home 309-311 Decatur St., Cumberland, MD 21502</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.					Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Dehydration, Hypernatremia, Hyperkalemia</b>					24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Thomas E. Chappel</b>		29c. LICENSE NUMBER <b>MD 35135</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/14/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Thomas E. Chappel MD 912 Selby Dr. Cumberland MD</b>					
31. DATE FILED (Month, Day, Year) <b>FEB 15 1991</b>		32. REGISTRAR'S SIGNATURE <b>Gina Davidson-Randall</b>			



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

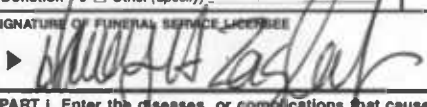


TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05657

1. DECEASED'S NAME (First, Middle, Last) <b>MATHIAS JOHN</b>				2. DATE OF DEATH MONTH DAY YEAR <b>February 13, 1991</b>				3. TIME OF DEATH M <b>10:25P</b>					
4. SOCIAL SECURITY NUMBER <b>233-26-8212</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		8. AGE (In yrs. last birthday) <b>84</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS <b>04/22/1906</b>		7. DATE OF BIRTH (Month, Day, Year) <b>04/22/1906</b>		6. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Memorial Hospital &amp; Medical Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Cumberland</b>				9c. COUNTY OF DEATH <b>Allegany</b>					
10a. STATE <b>MD</b>		10b. COUNTY <b>ALLEGANY</b>		10c. CITY, TOWN OR LOCATION <b>CORRIGANVILLE</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER <b>MT SAVAGE RD, P O BOX 146</b>				10f. ZIP CODE <b>21524</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>1922-1924</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>Collega (1-4 or 5+)</b>				15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>OWNER/OPERATOR</b>				15b. KIND OF BUSINESS/INDUSTRY <b>RETAIL SERVICE STATION</b>					
17. FATHER'S NAME (First, Middle, Last) <b>HOWARD MADDEN</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>NELLIE EVERLINE</b>									
19a. INFORMANT'S NAME (Type/Print) <b>DAVID W. RIZER</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1825 REISTERBORO RD, HAGERSTOWN, MD 21740</b>									
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify):				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>HILLCREST BURIAL PARK</b>				20c. LOCATION — City or Town, State <b>CUMBERLAND, MD 21502</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>HARVEY H. ZEIGLER FUNERAL HOME HYNDMAN, PA 15545-0636</b>									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition) → <b>a. Aspiration Pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>b. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>c. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>d.</b>										Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Cerebrovascular Accident</b> <b>Diabetes Mellitus</b>										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER 								29c. LICENSE NUMBER <b>D14865</b>		29d. DATE SIGNED (Month, Day, Year) <b>2-15-91</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Barrera Memorial Hospital Medical Building, Cumberland, MD 21502</b>													
31. DATE FILED (Month, Day, Year) <b>FEB 15 1991</b>				32. REGISTRAR'S SIGNATURE 									





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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Roger Nathaniel Medford</b>				2. DATE OF DEATH MONTH DAY YEAR <b>2 17 1991</b>		3. TIME OF DEATH <b>8:45P M</b>	
4. SOCIAL SECURITY NUMBER <b>215-01-1232A</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>77 YRS.</b>		7. DATE OF BIRTH (Month, Day, Year) <b>07/07/13</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Memorial Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Easton</b>	
9c. COUNTY OF DEATH <b>Talbot</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Caroline</b>	
10c. CITY, TOWN OR LOCATION <b>Federalsburg</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>308 Morris Avenue</b>	
10f. ZIP CODE <b>21632</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW II</b>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+) <b>2</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Oil Retailer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Oil Distribution</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Nathaniel W. Medford</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Alda Wright Medford</b>			
19a. INFORMANT'S NAME (Type/Print) <b>H. Nona Medford</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>308 Morris Ave., Federalsburg, MD 21632</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Hill Crest Cemetery 2/21</b>		20c. LOCATION — City or Town, State <b>Federalsburg, Md</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Michael F. Eskow</b>				22. NAME AND ADDRESS OF FACILITY <b>Frampton-Hawkins-Eskow Funeral Home PO Box 43, Federalsburg, MD 21632</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>COLON CANCER</b> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death <b>8 mo</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>[Signature]</b>				29c. LICENSE NUMBER <b>201235</b>		29d. DATE SIGNED (Month, Day, Year) <b>2-18-91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) <b>FEB 20 '91</b>				32. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



CONFIDENTIAL

CONFIDENTIAL

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CONFIDENTIAL

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Eddie C Magee</b>				2. DATE OF DEATH MONTH <b>2</b> DAY <b>16</b> YEAR <b>91</b>		3. TIME OF DEATH <b>3:08<sup>AM</sup></b>	
4. SOCIAL SECURITY NUMBER <b>216-14-2878</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>69</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>April 5, 1921</b>	
8. BIRTHPLACE (State or Foreign Country) <b>NYC</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Memorial Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Easton</b>	
9c. COUNTY OF DEATH <b>Talbot</b>				10a. STATE <b>MARYLAND</b>			
10b. COUNTY <b>Caroline</b>				10c. CITY, TOWN OR LOCATION <b>Federalsburg</b>			
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>P.O. Box 92 (Laurel Grove Rd.)</b>			
10f. ZIP CODE <b>21632</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW II</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>3</b> College (1-4 or 5+) <b>3</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Trade Embalmer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Funeral Homes</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Robert Leonard Magee</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Ethel Mae Turner</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Ms. Maxine Magee</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. Box 92, Federalsburg, MD 21632</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Eastern Shore Veterans 2/19</b>		DATE <b>Hurlock, Md.</b>		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Michael F. Eskow</b>				22. NAME AND ADDRESS OF FACILITY <b>Hampton-Hawkins-Eskow, P.A. PO Box 43, Federalsburg, MD 21632</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Hepatorenal syndrome</b> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Alcoholic cirrhosis</b>						Approximate interval Between Onset and Death <b>1 W</b> <b>10 Y</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic renal failure</b> <b>Diabetes mellitus</b>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>[Signature] MD</b>				29c. LICENSE NUMBER <b>D35284</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/16/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>PO Box 122 Goldsboro MD 21636</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 20 '91</b>				32. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 05660

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) <b>AMBER NICOLE MORRIS</b>				2. DATE OF DEATH MONTH: <b>2</b> DAY: <b>12</b> YEAR: <b>91</b>		3. TIME OF DEATH <b>7:38 A M</b>	
4. SOCIAL SECURITY NUMBER <b>N/A</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) YRS. MONTHS DAYS HOURS MIN. <b>15</b>		7. DATE OF BIRTH (Month, Day, Year) <b>01/28/91</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9. COUNTY OF DEATH <b>Talbot</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Easton Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Easton</b>		9c. COUNTY OF DEATH <b>Talbot</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Caroline</b>		10c. CITY, TOWN OR LOCATION <b>Federalburg</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>Rt. 2, Box 386 T</b>				10f. ZIP CODE <b>21632</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>N/A</b> College (1-4 or 5+) <b>N/A</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>N/A</b>		16b. KIND OF BUSINESS/INDUSTRY <b>N/A</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Robert Wayne Morris</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Cynthia Capri Adams</b>			
19a. INFORMANT'S NAME (Type/Print) <b>R. Wayne Morris</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Rt. 2, Box 386T, Federalburg, MD 21632</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Hill Crest Cemetery 2/15 Federalburg, MD</b>		20c. DATE <b>2/15</b>		20d. LOCATION — City or Town, State <b>Federalburg, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Michael J. Colson</b>				22. NAME AND ADDRESS OF FACILITY <b>Frampton-Hawkins-Eskow Funeral Home PO Box 43, Federalburg, MD 21632</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Sudden Infant Death Syndrome</b>  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>[Signature]</b>				29c. LICENSE NUMBER <b>OCME</b>		29d. DATE SIGNED (Month, Day, Year) <b>2-12-91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Ann M. Dixon, M.D. 111 Penn Street Baltimore, MD 21201</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 20 91</b>		32. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020  
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				CERTIFICATE OF DEATH				REG. NO.							
1. DECEDENT'S NAME (First, Middle, Last) <b>JOHN BENJAMIN MOLL, JR.</b>								2. DATE OF DEATH MONTH DAY YEAR <b>FEB. 16, 1991</b>				3. TIME OF DEATH 12:10 p.m.							
4. SOCIAL SECURITY NUMBER <b>222-09-1708</b>				5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>81</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>5-6-1909</b>		8. BIRTHPLACE (State or Foreign Country) <b>PENNA.</b>									
9a. FACILITY NAME (If not institution, give street and number) <b>MERIDIAN NURSING CENTER-PINES</b>								9b. CITY, TOWN OR LOCATION OF DEATH <b>EASTON</b>				9c. COUNTY OF DEATH <b>TALBOT</b>							
10a. STATE <b>MARYLAND</b>				10b. COUNTY <b>TALBOT</b>				10c. CITY, TOWN OR LOCATION <b>OXFORD</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
10e. STREET AND NUMBER <b>200 TRED AVON AVENUE</b>								10f. ZIP CODE <b>21654</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>5</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>ARTIST</b>				16b. KIND OF BUSINESS/INDUSTRY											
17. FATHER'S NAME (First, Middle, Last) <b>JOHN BENJAMIN MOLL, SR.</b>								18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>DEBORAH KOCHER</b>											
19a. INFORMANT'S NAME (Type/Print) <b>ELIZABETH P. MOLL</b>								19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. BOX 178 OXFORD, MARYLAND 21654</b>											
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>EASTERN SHORE CREMATORIUM</b>				20c. LOCATION — City or Town, State <b>GEORGETOWN, DEL.</b>											
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>M.E. Newman</i> <b>CFSP</b>								22. NAME AND ADDRESS OF FACILITY <b>NEWMAN FUNERAL HOME</b> <b>200 S. HARRISON ST. EASTON, MD 21601</b>											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CARDIAC ARREST</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST</b> b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.												Approximate Interval Between Onset and Death <b>IMMEDIATE</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ORGANIC BRAIN DISEASE</b>												24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)															
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY <b>M</b>				28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
				28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>C.W. BARN M.D.</b>								29c. LICENSE NUMBER <b>D00250</b>				29d. DATE SIGNED (Month, Day, Year) <b>2/18/91</b>							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>C.W. BARN, 415 E. DOVER, EASTON, MD, 21601</b>																			
31. DATE FILED (Month, Day, Year) <b>FEB 19 1991</b>								32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>											





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05662

1. DECEDENT'S NAME (First, Middle, Last) <i>Eugenio Kincaid MOWEN</i>				2. DATE OF DEATH MONTH DAY YEAR <i>February 20, 1991</i>		3. TIME OF DEATH <i>4:00 AM</i>			
4. SOCIAL SECURITY NUMBER <i>214-09-0852-A</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>80</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>May 15, 1910</i>		8. BIRTHPLACE (State or Foreign Country) <i>Maryland</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>11 W. Baltimore St., Apt. 313</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Hagerstown</i>			9c. COUNTY OF DEATH <i>Washington</i>		
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Washington</i>		10c. CITY, TOWN OR LOCATION <i>Hagerstown</i>			10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
10e. STREET AND NUMBER <i>11 W. Baltimore St.</i>				10f. ZIP CODE <i>21740</i>		10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <i>white</i>		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>0</i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>production manager</i>			16b. KIND OF BUSINESS/INDUSTRY <i>aircraft industry</i>		
17. FATHER'S NAME (First, Middle, Last) <i>John C. Mowen</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Addie Mae Schwartz</i>					
19a. INFORMANT'S NAME (Type/Print) <i>Helen Mowen</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>11 W. Baltimore St., Hagerstown, Md. 21740</i>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Rest Haven Cemetery</i>			20c. LOCATION — City or Town, State <i>Hagerstown, Maryland</i>		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Scott J. Minnich</i>				22. NAME AND ADDRESS OF FACILITY <i>MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740</i>					
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. Arteriosclerotic Cardiovascular Disease</i> DUE TO (OR AS A CONSEQUENCE OF): and <i>b. Chronic Obstructive Pulmonary Disease</i> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  c. DUE TO (OR AS A CONSEQUENCE OF):  d. DUE TO (OR AS A CONSEQUENCE OF):						Approximate Interval Between Onset and Death <i>Many Years</i>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Edward W. Ditto, III</i>						29c. LICENSE NUMBER <i>DO 1062</i>		29d. DATE SIGNED (Month, Day, Year) <i>Feb. 20, 1991</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Edward W. Ditto, III, M.D., 217 West Washington Street, Hagerstown, Maryland 21740</i>									
31. DATE FILED (Month, Day, Year) <i>FEB 20 '91</i>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson Randall</i>					

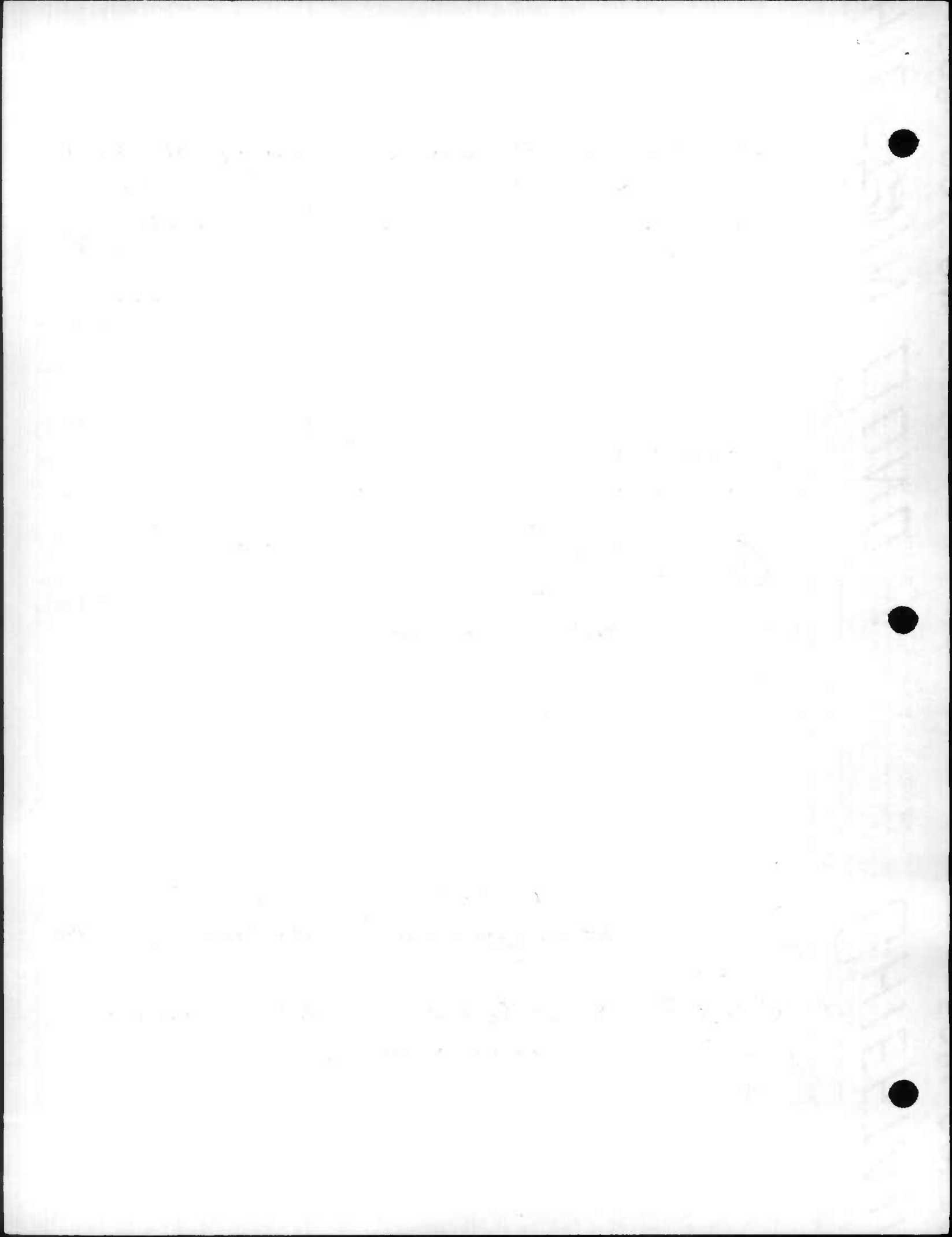


TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				CERTIFICATE OF DEATH				REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last) ROBERT DONALD MITTEN JR.								2. DATE OF DEATH MONTH DAY YEAR 02 19 1991				3. TIME OF DEATH HOURS MIN. SEC. 0900 AM			
4. SOCIAL SECURITY NUMBER 216-27-2750				5. SEX MALE		6. AGE (In yrs. last birthday) 6 YRS.		7. DATE OF BIRTH MONTH DAY YEAR 03/11/84		8. BIRTHPLACE (State or Foreign) PENNSYLVANIA					
9a. FACILITY NAME (If not institution, give street and number) 11327B LIBERTY RD.								9b. CITY, TOWN OR LOCATION OF DEATH FREDERICK (NR. LIBERTYTOWN)				9c. COUNTY OF DEATH FREDERICK			
10a. STATE MD				10b. COUNTY FREDERICK				10c. CITY, TOWN OR LOCATION FREDERICK				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER 11327B LIBERTY RD.								10f. ZIP CODE 21701				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES NO				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO NO				14. RACE — American Indian, Black, White, etc. WHITE			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) K College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) STUDENT				16b. KIND OF BUSINESS/INDUSTRY ELEMENTARY							
17. FATHER'S NAME (First, Middle, Last) ROBERT D. MITTEN, SR.								18. MOTHER'S NAME (First, Middle, Maiden Surname) CANDY LOU HARTLAUB							
19a. INFORMANT'S NAME (Type/Print) ROBERT D. MITTEN, SR.								19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11327B LIBERTY RD. FREDERICK MD 21701							
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) LUTHERAN CEMETERY				20c. LOCATION — City or Town, State UNIONTOWN, MD							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Catherine D. Hartzler</i>								22. NAME AND ADDRESS OF FACILITY D. D. HARTZLER & SONS LIBERTYTOWN, MD							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>MULTIPLE TRAUMA</u> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST												Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.															
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 5 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) 02 19 91		28b. TIME OF INJURY 0830		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED Struck by truck					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER Robert R. Roberts MD				29c. LICENSE NUMBER D09867				29d. DATE SIGNED (Month, Day, Year) 02/19/91			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 15 W 7th ST Frederick MD 21701															
31. DATE FILED (Month, Day, Year) FEB 21 '91				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>											



TO THE HOSPITAL, DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				CERTIFICATE OF DEATH				REG. NO.							
1. DECEDENT'S NAME (First, Middle, Last) BUFORD J. MCDONALD								2. DATE OF DEATH MONTH DAY YEAR FEBRUARY 17, 1991				3. TIME OF DEATH 5:10 A M							
4. SOCIAL SECURITY NUMBER 220-16-2638				5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 64 YRS.		7. DATE OF BIRTH (Month, Day, Year) 07-06-1926		8. BIRTHPLACE (State or Foreign Country) MD									
9a. FACILITY NAME (If not institution, give street and number) Memorial Hospital & Medical Center								9b. CITY, TOWN OR LOCATION OF DEATH Cumberland				9c. COUNTY OF DEATH Allegany							
10a. STATE MD				10b. COUNTY Allegany				10c. CITY, TOWN OR LOCATION Cumberland,				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
10e. STREET AND NUMBER 632 Columbia Avenue								10f. ZIP CODE 21502				10g. CITIZEN OF WHAT COUNTRY? USA							
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Korean				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: white							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) C.A. Dept./retired Bureau of Mines				16b. KIND OF BUSINESS/INDUSTRY Textile/ State of MD											
17. FATHER'S NAME (First, Middle, Last) Alfred McDonald								18. MOTHER'S NAME (First, Middle, Maiden Surname) Ruth Smith											
19a. INFORMANT'S NAME (Type/Print) Mrs. Elizabeth D. McDonald								19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 632 Columbia Avenue Cumberland, MD 21502											
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery or other place) Restlawn Memorial Park				DATE				20c. LOCATION — City or Town, State LaVale, MD							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE James F. Scarpelli								22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home Cumberland, MD 21502											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Ventricular fibrillation Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST CV dysfunction Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):												Approximate Interval Between Onset and Death							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. COPD.												24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)															
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M				28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
28d. DESCRIBE HOW INJURY OCCURRED								28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)											
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																			
29b. SIGNATURE AND TITLE OF CERTIFIER R. S. Shrestha MD								29c. LICENSE NUMBER D20258				29d. DATE SIGNED (Month, Day, Year) 2/18/91							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. S. Shrestha Memorial Hospital & Medical Center Cumberland, MD 21502																			
31. DATE FILED (Month, Day, Year) FEB 19 1991								32. REGISTRAR'S SIGNATURE John Anderson-Randall											



91 05665

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>IZETTA THERESA MAUK</b>						2. DATE OF DEATH MONTH DAY YEAR <b>February 13, 1991</b>		3. TIME OF DEATH <b>2:17 P M</b>	
4. SOCIAL SECURITY NUMBER <b>214-16-2382</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (in yrs. last birthday) <b>76</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>05-28-1914</b>		8. BIRTHPLACE (State or Foreign Country) <b>MD</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Memorial Hospital</b>						9b. CITY, TOWN OR LOCATION OF DEATH <b>Cumberland</b>		9c. COUNTY OF DEATH <b>Allegany</b>	
10a. STATE <b>MD</b>		10b. COUNTY <b>Allegany</b>		10c. CITY, TOWN OR LOCATION <b>Cumberland</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER <b>Bedford Road</b>				10f. ZIP CODE <b>21502</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>12</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>former employee</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Glass / Textile</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Samuel P. Friend</b>						18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Jane Engle</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mr. George Wolfe</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>726 White Avenue Cumberland, MD 21502</b>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> 2 Cremation <input type="checkbox"/> 3 Removal from State <input type="checkbox"/> 4 Donation <input type="checkbox"/> 5 Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Sunset Memorial Park</b>		20c. LOCATION — City or Town, State <b>Cumberland, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>James F. Scarpelli</b>				22. NAME AND ADDRESS OF FACILITY <b>Scarpelli Funeral Home Cumberland, MD 21502</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ACUTE MYOCARDIAL INFARCTION</b> DUE TO (OR AS A CONSEQUENCE OF): <b>CAD</b>  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>ILD - PULMONARY FIBROSIS</b> DUE TO (OR AS A CONSEQUENCE OF): <b>RESPIRATORY FAILURE</b>						Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CIA LUNG</b>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> 2 ER/Outpatient <input type="checkbox"/> 3 DOA OTHER: <input type="checkbox"/> 4 Nursing Home <input type="checkbox"/> 5 Residence <input type="checkbox"/> 6 Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> 5 Pending Investigation <input type="checkbox"/> 2 Accident <input type="checkbox"/> 6 Could not be determined <input type="checkbox"/> 3 Suicide <input type="checkbox"/> 4 Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
				28d. DESCRIBE NOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						29b. SIGNATURE AND TITLE OF CERTIFIER <b>Dr. Raver</b>		29c. LICENSE NUMBER <b>D18769</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Raver, Memorial Hospital, Cumberland, MD 21502</b>						29d. DATE SIGNED (Month, Day, Year) <b>2/15/91</b>			
31. DATE FILED (Month, Day, Year) <b>FEB 19 1991</b>				32. REGISTRAR'S SIGNATURE <b>Johanna Davidson-Randall</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. Page 6 should be retained by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last) <b>MARGARET HANNAH MATERS</b>					2. DATE OF DEATH MONTH DAY YEAR <b>February 13, 1991</b>		3. TIME OF DEATH H M <b>8:50P</b>
4. SOCIAL SECURITY NUMBER <b>236-76-2280</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>91</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>Oct. 22, 1899</b>		8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>MEMORIAL HOSPITAL &amp; MEDICAL CENTER</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Cumberland</b>		9c. COUNTY OF DEATH <b>Allegany</b>	
10a. STATE <b>WEST VA</b>		10b. COUNTY <b>MINERAL</b>		10c. CITY, TOWN OR LOCATION <b>RIDGELEY</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>2 JONES STREET</b>				10f. ZIP CODE <b>26753</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOMEMAKER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>HOME</b>			
17. FATHER'S NAME (First, Middle, Last) <b>LEWIS JONES</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>EMMA VALENTINE</b>			
19a. INFORMANT'S NAME (Type/Print) <b>HOWARD MATERS</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. BOX 449 - RIDGELEY, WV 26753</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>RESTLAWN MEMORIAL GARDENS</b>		20c. LOCATION — City or Town, State <b>LAVALE, MARYLAND</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George D. Upchurch</i>				22. NAME AND ADDRESS OF FACILITY <b>GEORGE-UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST. - CUMBERLAND, MD 21502</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Sepsis</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <b>CHF</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>dementia</b> DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>		29c. LICENSE NUMBER <b>D31579</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/14/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Suresh 517 Oldtown Road, Cumberland, MD 21502</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 13 1991</b>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

and other things

91 05667

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) EDGAR C. NAZELROD				2. DATE OF DEATH MONTH DAY YEAR February 11, 1991		3. TIME OF DEATH 10:55 a <sup>m</sup>	
4. SOCIAL SECURITY NUMBER 217-10-1125		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 81 YRS.		7. DATE OF BIRTH (Month, Day, Year) 09-12-1909	
8. BIRTHPLACE (State or Foreign Country) WV				9a. FACILITY NAME (If not institution, give street and number) Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Cumberland	
9c. COUNTY OF DEATH Allegany				10a. STATE MD		10b. COUNTY Allegany	
10c. CITY, TOWN OR LOCATION Cumberland,				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 12 W. Second Street Apt. B	
10f. ZIP CODE 21502				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) ret. maintenance dept.		16b. KIND OF BUSINESS/INDUSTRY Textile	
17. FATHER'S NAME (First, Middle, Last) Jonah P. Nazelrod				18. MOTHER'S NAME (First, Middle, Maiden Surname) Nannie I. (nm)			
19a. INFORMANT'S NAME (Type/Print) Mrs. Isabel Hartsock				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2260 University Blvd. N. Jacksonville, FL 32211			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Hillcrest Burial Park		20c. LOCATION — City or Town, State Cumberland, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE James F. Scarpelli				22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home Cumberland, MD 21502			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardio-Respiratory Arrest. Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. Acute Bronchitis c. Hydropneumothorax d. Possible Ca. in Chest							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER Dr. O. Zaman				29c. LICENSE NUMBER D 23371		29d. DATE SIGNED (Month, Day, Year) 2/13/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. O. Zaman-Memorial Hospital Medical Building-Cumberland, MD 21502							
31. DATE FILED (Month, Day, Year) FEB 14 1991				32. REGISTRAR'S SIGNATURE John Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05668

1. DECEDENT'S NAME (First, Middle, Last) CATHERINE M. NUCKER				2. DATE OF DEATH MONTH 2 DAY 13 YEAR 91		3. TIME OF DEATH 3:35 P M				
4. SOCIAL SECURITY NUMBER 185-20-6599		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 89 YRS.		7. DATE OF BIRTH (Month, Day, Year) 9/05/01		8. BIRTHPLACE (State or Foreign Country) PENNSYLVANIA		
9a. FACILITY NAME (If not institution, give street and number) FRIENDS NURSING HOME				9b. CITY, TOWN OR LOCATION OF DEATH SANDY SPRING			9c. COUNTY OF DEATH MONTGOMERY			
10a. STATE MARYLAND			10b. COUNTY Prince Georges		10c. CITY, TOWN OR LOCATION Laurel			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER 8245 Imperial Drive				10f. ZIP CODE 20708			10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: WHITE			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 1-12 College (1-4 or 5+) College			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker			16b. KIND OF BUSINESS/INDUSTRY Own Home				
17. FATHER'S NAME (First, Middle, Last) James Moore				18. MOTHER'S NAME (First, Middle, Maiden Surname) Sarah Neill						
19a. INFORMANT'S NAME (Type/Print) William J. Nucker				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8245 Imperial Dr. Laurel, Md. 20708						
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Everly Crematory			20c. LOCATION — City or Town, State Fairfax, VA.					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY Hines/Rinaldi Funeral Home 11800 New Hampshire Ave., Sil. Spr, Md. 20904						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Advanced Alzheimer's Disease</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Papillary Disease of Uterus to</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>metastatic</i> DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death 5 years "			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide			28a. DATE OF INJURY (Month, Day, Year) NONE		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
			28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Gustavo S. Belaval, MD</i>						29c. LICENSE NUMBER D14715		29d. DATE SIGNED (Month, Day, Year) 13 Feb 1991		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Gustavo S. Belaval - Leisure World Medical Center Silver Spring, Md 20906										
31. DATE FILED (Month, Day, Year) FEB 19 '91			32. REGISTRAR'S SIGNATURE <i>Jake Davidson-Randall</i>							



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, & 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
**IMPORTANT:** If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05669

1. DECEDENT'S NAME (First, Middle, Last) <b>Charles Novak</b>				2. DATE OF DEATH MONTH <b>2</b> DAY <b>13</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>M</b>				
4. SOCIAL SECURITY NUMBER <b>216-12-3495</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>84</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>4-21-1906</b>		8. BIRTHPLACE (State or Foreign Country) <b>New Jersey</b>		
9a. FACILITY NAME (If not institution, give street and number) <b>Anne Arundel Medical Ctr.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Annapolis</b>			9c. COUNTY OF DEATH <b>Anne Arundel</b>			
10a. STATE <b>Md.</b>		10b. COUNTY <b>Anne Arundel</b>		10c. CITY, TOWN OR LOCATION <b>Davidsonville</b>			10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER <b>3502 Riva Road</b>				10f. ZIP CODE <b>21035</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+) <b>College</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Farmer</b>			15b. KIND OF BUSINESS/INDUSTRY <b>Farming</b>					
17. FATHER'S NAME (First, Middle, Last) <b>Charles Novak</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Anna Opalszky</b>						
19a. INFORMANT'S NAME (Type/Print) <b>Virginia Cwikla</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1657 Aidenn Lair Rd. Dresher, Pa. 19025</b>						
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metropolitan Crematory</b>			20c. LOCATION — City or Town, State <b>Alexandria, Va.</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Jeffrey S. Taylor</i>				22. NAME AND ADDRESS OF FACILITY <b>Taylor Funeral Chapel Annapolis, Md.</b>						
23. PART I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Unattended Death</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. <b>Probable Acute MI</b> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Unseen Disease with Recent G.I. Bleed</b> <b>CAD</b> <b>D.M.</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>223557</b>		29d. DATE SIGNED (Month, Day, Year) <b>2-14-91</b>				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>ANTHONY M. CAPUTO</b> <b>132 HOLIDAY COURT ANNAPOLIS, MD 21401</b>										
31. DATE FILED (Month, Day, Year) <b>FEB 19 1991</b>			32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>							

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1111



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Joseph Henry Nichols</b>				2. DATE OF DEATH MONTH <b>February</b> DAY <b>4</b> YEAR <b>1991</b> 1:15PM											
4. SOCIAL SECURITY NUMBER <b>218-30-1079</b>		5. SEX <b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>84</b> YRS.	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>		7. DATE OF BIRTH (Month, Day, Year) <b>12-16-1906</b>		8. BIRTHPLACE (State or Foreign Country) <b>Delaware</b>					
9a. FACILITY NAME (If not institution, give street and number) <b>Memorial Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Easton</b>				9c. COUNTY OF DEATH <b>Talbot</b>							
RESIDENCE OF DECEDENT															
10a. STATE <b>Md.</b>		10b. COUNTY <b>Talbot</b>		10c. CITY, TOWN OR LOCATION <b>Easton</b>				10d. INSIDE CITY LIMITS? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER <b>Rt. #1 Box 503</b>				10f. ZIP CODE <b>21601</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
11. MARITAL STATUS <b>1</b> <input type="checkbox"/> Never Married <b>2</b> <input checked="" type="checkbox"/> Married <b>3</b> <input type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>College (1-4 or 5+)</b> <b>secondary</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Farmer</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Farming</b>							
17. FATHER'S NAME (First, Middle, Last) <b>Joseph Nichols</b>						16. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Rhoda Nichols</b>									
19a. INFORMANT'S NAME (Type/Print) <b>Elva Mae Nichols</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Route 1 Box 503 21601</b>											
20a. METHOD OF DISPOSITION <b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State <b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Richardson Cemetery 2/7/91</b>				DATE <b>2/7/91</b>		20c. LOCATION — City or Town, State <b>Easton, Md.</b>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Bernie Smith</b>				22. NAME AND ADDRESS OF FACILITY <b>P.O. Box 928 Hurlbuck, Md. 21643</b>											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>a. Pneumonia</b> <b>DUE TO (OR AS A CONSEQUENCE OF):</b> <b>b.</b> <b>DUE TO (OR AS A CONSEQUENCE OF):</b> <b>c.</b> <b>DUE TO (OR AS A CONSEQUENCE OF):</b> <b>d.</b> <b>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST</b>												Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes</b> <b>Chronic Renal Failure</b>												24a. WAS AN AUTOPSY PERFORMED? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1</b> <input checked="" type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA OTHER: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH <b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation <b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined <b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED							
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) <b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER <b>[Signature]</b>						29c. LICENSE NUMBER <b>D32036</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/5/91</b>							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Gary Spruse P.O. Box 210 Waverly, Md 21658</b>															
31. DATE FILED (Check only one) <b>Feb - 7 '91</b>				32. REGISTRAR'S SIGNATURE <b>[Signature]</b>											



**STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH**

91 05671

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>KIRSTEN NAEGELI (nm)</b>				2. DATE OF DEATH MONTH <b>2</b> DAY <b>20</b> YEAR <b>91</b>		3. TIME OF DEATH <b>1:20 p.m.</b>		
4. SOCIAL SECURITY NUMBER <b>045-38-1644</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>81</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>09-29-09</b>		
8. BIRTHPLACE (State or Foreign Country) <b>Denmark</b>				9a. FACILITY NAME (If not institution, give street and number) <b>7 Kalten Road</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Westminster</b>		
9c. COUNTY OF DEATH <b>Carroll</b>				10a. STATE <b>Maryland</b>				
10b. COUNTY <b>Carroll</b>				10c. CITY, TOWN OR LOCATION <b>Westminster</b>				
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>7 Kalten Road</b>				
10f. ZIP CODE <b>21157</b>				10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>				
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Clerk</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Department Store</b>				
17. FATHER'S NAME (First, Middle, Last) <b>Gustav Jensen</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Kristine Ptrine Stefanie Petersen</b>				
19a. INFORMANT'S NAME (Type/Print) <b>Markus Jürg Naegeli</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7 Kalten Road, Westminster, MD 21157</b>				
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Carroll Crematory</b>		20c. LOCATION — City or Town, State <b>Hampstead, Maryland</b>				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Myers Funeral Home 91 Willis Street, Westminster, MD 21157</b>				
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death <b>15 YRS</b>	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CHRONIC OBSTRUCTIVE LUNG DISEASE</b>								
DUE TO (OR AS A CONSEQUENCE OF):								
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							29b. SIGNATURE AND TITLE OF CERTIFIER 	29c. LICENSE NUMBER <b>504079</b>
29d. DATE SIGNED (Month, Day, Year) <b>2/20/91</b>							30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)	
31. DATE FILED (Month, Day, Year) <b>FEB 21 '91</b>		32. REGISTRAR'S SIGNATURE 						

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Michael Dewayne Proctor</u>				2. DATE OF DEATH MONTH <u>02</u> DAY <u>12</u> YEAR <u>91</u>		3. TIME OF DEATH <u>5.20 P M</u>	
4. SOCIAL SECURITY NUMBER <u>Unknown</u>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <u>29</u> YRS.	7. DATE OF BIRTH (Month, Day, Year) <u>1/5/62</u>		8. BIRTHPLACE (State or Foreign Country) <u>Mississippi</u>	
9a. FACILITY NAME (If not institution, give street and number) <u>Shady Grove Adventist Hospital</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>Rockville</u>		9c. COUNTY OF DEATH <u>Montgomery</u>	
10a. STATE <u>Md</u>		10b. COUNTY <u>Montgomery</u>		10c. CITY, TOWN OR LOCATION <u>Rockville</u>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <u>1307 Seven Locks Road</u>				10f. ZIP CODE <u>20852</u>		10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>Black</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>4 years</u>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Unknown</u>		15b. KIND OF BUSINESS/INDUSTRY <u>N/A</u>			
17. FATHER'S NAME (First, Middle, Last) <u>James Allen</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Susie Proctor</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Susie Proctor Gray</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Fleming Road Indinaola, Miss. 38751</u>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Suburban Crematory 2/15/91</u>		20c. LOCATION — City or Town, State <u>Silver Spring, Md.</u>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <u>W.H. Bacon Funeral Home</u> <u>3447 14th Street, N.W. Wash. DC</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>a. AMOXAPINE INTOXICATION</u> DUE TO (OR AS A CONSEQUENCE OF): Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <u>2/11/91</u>		28b. TIME OF INJURY <u>UNKNOWN</u>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <u>DETENTION CENTER</u>		28e. DESCRIBE HOW INJURY OCCURRED <u>SUBJECT INGESTED DRUGS</u>			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <u>1307 SEVEN LOCKS RD ROCKVILLE, MARYLAND</u>					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER <u>BCME</u>		29d. DATE SIGNED (Month, Day, Year) <u>2-14-91</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>A.M. DIXON M.D. 111 KENN ST, BALTO. MD. 21201</u>							
31. DATE FILED (Month, Day, Year) <u>FEB 28 1991</u>		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 05673

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Shirley Ford Prendergast</b>				2. DATE OF DEATH MONTH DAY YEAR <b>February 4 1991</b>		3. TIME OF DEATH <b>10:09PM</b>	
4. SOCIAL SECURITY NUMBER <b>216-28-0711</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>58</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>11/17/32</b>	
8. BIRTHPLACE (State or Foreign Country) <b>MD</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Memorial Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Easton</b>	
9c. COUNTY OF DEATH <b>Talbot</b>				10a. STATE <b>MD</b>		10b. COUNTY <b>Caroline</b>	
10c. CITY, TOWN OR LOCATION <b>Denton</b>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>107 Market Street</b>	
10f. ZIP CODE <b>21629</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>Korea</b>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9th</b> College (1-4 or 5+) <b></b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Unknown</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Unknown</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Kenneth R. Prendergast</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>905C Royal Street Annapolis, MD 21401</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Eastern Shore Crematorium</b>		20c. LOCATION — City or Town, State <b>Georgetown, DE</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>JOHN R. MERCERON</b>				22. NAME AND ADDRESS OF FACILITY <b>Newnam Funeral Home 200 S. Harrison St. Easton, MD</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide			
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. DESCRIBE HOW INJURY OCCURRED	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D24769</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/5/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>L. Thomas Divilio M.D., 404 Marvel Court, Easton, Md. 21601</b>							
31. DATE FILED (Month, Day, Year) <b>FEB - 8 '91</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Handwritten text, possibly a signature or name, appearing in the lower right section of the page.

Handwritten text, possibly a signature or name, appearing in the lower middle section of the page.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05674

1. DECEDENT'S NAME (First, Middle, Last) <b>Herman H. Pinder</b>				2. DATE OF DEATH MONTH <b>02</b> DAY <b>18</b> YEAR <b>91</b>		3. TIME OF DEATH <b>20:50 P.</b>	
4. SOCIAL SECURITY NUMBER <b>214-16-4116</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		8. AGE (In yrs. last birthday) <b>83</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>2/3/08</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Dorchester Gen. Hosp. Tal</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Camb-idge</b>		9c. COUNTY OF DEATH <b>Dorchester</b>	
10a. STATE <b>Md.</b>		10b. COUNTY <b>Dorchester</b>		10c. CITY, TOWN OR LOCATION <b>Vienna</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>RT I Box 123</b>				10f. ZIP CODE <b>21869</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (14 or 5+) <input type="checkbox"/>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>Louis Pinder</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Maria Lee</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Louise Pinder</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>RT I Box 123 Vienna, Md. 21869</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Danelle C. Henry Buck</b>				22. NAME AND ADDRESS OF FACILITY <b>Henry F. H. Cambridge, Md. 21613</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Adenocarcinoma of rectum</b> DUE TO (OR AS A CONSEQUENCE OF): <b>with metastasis</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <b>with metastases</b> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death <b>1 year</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>_____</b>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <b>_____</b>		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Lewis M. Burdette, M.D.</b>				29c. LICENSE NUMBER <b>D00880</b>		29d. DATE SIGNED (Month, Day, Year) <b>18 Feb 91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Lewis Burdette, M.D. 4 Aurora St., Cambridge Md 21613</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 19 '91</b>				32. REGISTRAR'S SIGNATURE <b>Gelia Davidson-Randell</b>			



TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05675

1. DECEASED'S NAME (First, Middle, Last) <b>OIDA HELEN PERDEW</b>				2. DATE OF DEATH MONTH DAY YEAR <b>FEB. 16, 1991</b>		3. TIME OF DEATH <b>8:25 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>212-78-2592</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>84</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>JAN. 4, 1907</b>		8. BIRTHPLACE (State or Foreign Country) <b>PENNSYLVANIA</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>17 NATIONAL HIGHWAY</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>LAVALE</b>		9c. COUNTY OF DEATH <b>ALLEGANY</b>	
10a. STATE <b>MARYLAND</b>				10b. COUNTY <b>ALLEGANY</b>		10c. CITY, TOWN OR LOCATION <b>LAVALE</b>	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>17 NATIONAL HIGHWAY</b>			
10f. ZIP CODE <b>21502</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>UNKNOWN</b>		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>WORKER-SPINNING DEPT.</b>		16b. KIND OF BUSINESS/INDUSTRY <b>CELANESE CORPORATION</b>			
17. FATHER'S NAME (First, Middle, Last) <b>UNKNOWN</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ELLA MAE BENNETT</b>			
19a. INFORMANT'S NAME (Type/Print) <b>STANLEY PERDEW</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>301 ALLEGANY STREET - FROSTBURG, MD 21532</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>MT. HOPE CEMETERY</b>		20c. LOCATION — City or Town, State <b>HEWITT, PENNSYLVANIA</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George W. Upchurch</i>				22. NAME AND ADDRESS OF FACILITY <b>GEORGE-UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST-CUMBERLAND, MD 21502</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <b>DIABETES MELLITUS</b> DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d.						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CELLULITIS-RT LEG</b>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Paul Snow</i>		29c. LICENSE NUMBER <b>D09157</b>		29d. DATE SIGNED (Month, Day, Year) <b>FEB. 16, 1991</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>PAUL SNOW, M.D.-DEP. M.E.-123 W. THIRD STREET, CUMBERLAND, MD 21502</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 19 1991</b>		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					



91 05676

FOR STATE REGISTRAR JOHN ROBERT RICHARDSON **STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH** REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>John Richardson</b>		2. DATE OF DEATH MONTH <b>2</b> DAY <b>20</b> YEAR <b>91</b>		3. TIME OF DEATH <b>8:30 PM</b>	
4. SOCIAL SECURITY NUMBER <b>212 54 2712</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>42</b> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <b>5-8-48</b>		8. BIRTHPLACE (State or Foreign Country) <b>MD</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Seton Hill Manor</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>		9c. COUNTY OF DEATH <b>-</b>	
10a. STATE <b>MD</b>		10b. COUNTY <b>Calvert</b>		10c. CITY, TOWN OR LOCATION <b>Chesapeake Beach</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>4312 Calvert Drive</b>		10f. ZIP CODE <b>20732</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>Truck Loader</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Truck Loader</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Retail - Food</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Joe Boswell</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Ruth Richardson</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Faye Patricia Windsor</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>same as 10 above</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Southern Memorial Gardens</b>		20c. LOCATION — City or Town, State <b>Dunkirk (Calvert) MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>		22. NAME AND ADDRESS OF FACILITY <b>Rausch Funeral Home, Owings, MD 20736</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>AIDS</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  <b>Retinitis (AIDS) Hx. of PCP Candida Esophagitis</b>					Approximate interval Between Onset and Death <b>12 mos</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Retinitis (AIDS) Hx. of PCP Candida Esophagitis</b>					24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Jaime Punzalan MD</i>		29c. LICENSE NUMBER <b>D15124</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/21/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>JAIME PUNZALAN MD. 5214 Harford rd. Balto. MD. 21214</b>					
31. DATE FILED (Month, Day, Year) <b>FEB 22 1991</b>		32. REGISTRAR'S SIGNATURE <i>Joshua Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



REG. NO.

DHMH-16 Rev 1/89

**TO THE HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician, page 7 may be retained by the funeral director, page 8 may be retained by the coroner or medical examiner, and page 9 should be detached for use as the burial-transit permit.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**





91-878-003

FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05678

1. DECEDENT'S NAME (First, Middle, Last) <b>Ruth Helen Rawlings</b>				2. DATE OF DEATH MONTH DAY YEAR <b>02 14 1991</b>		3. TIME OF DEATH <b>9:20 A M</b>	
4. SOCIAL SECURITY NUMBER <b>216-28-7423</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>81</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>2-28-1909</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Anne Arundel General Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Annapolis</b>		9c. COUNTY OF DEATH <b>Anne Arundel</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Anne Arundel</b>		10c. CITY, TOWN OR LOCATION <b>Annapolis</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER <b>129 Bay Shore Avenue</b>				10f. ZIP CODE <b>21403</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Rudolf Rupp</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Burggraf</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Robert A. Rawlings</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3305 Harness Creek Rd. Annapolis, Md. 21403</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, or other place) <b>Cedar Bluff Cemetery 2-17</b>		20c. LOCATION — City or Town, State <b>Annapolis, Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Robert S. Saylor</b>				22. NAME AND ADDRESS OF FACILITY <b>Taylor Funeral Chapel Annapolis, Md.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Arteriosclerotic cardiovascular disease</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <b>8</b> YES <input type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>Donald G. Wright</b>		29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>02-16-1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DONALD G. WRIGHT, M.D., DEP. CH. MED. EX. 111 Penn St., Balto., Md., 21201</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 19 1991</b>		32. REGISTRAR'S SIGNATURE <b>Julia Davidson</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Feb 19 1951

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR STATE REGISTRAR						STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE						91 05679			
CERTIFICATE OF DEATH						REG. NO.									
1. DECEDENT'S NAME (First, Middle, Last) Hilda J. Roberts						2. DATE OF DEATH MONTH DAY YEAR 2 12 91		3. TIME OF DEATH 10:30 p M							
4. SOCIAL SECURITY NUMBER 213 12 9883		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) 10/26/17		8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not institution, give street and number) Frostburg Community Hospital						9b. CITY, TOWN OR LOCATION OF DEATH Frostburg, MD				9c. COUNTY OF DEATH Allegany					
RESIDENCE OF DECEDENT															
10a. STATE Maryland		10b. COUNTY Allegany		10c. CITY, TOWN OR LOCATION Nikep				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER Box D 2				10f. ZIP CODE 21546		10g. CITIZEN OF WHAT COUNTRY? USA									
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) n/a				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Health				16b. KIND OF BUSINESS/INDUSTRY Finan Center							
17. FATHER'S NAME (First, Middle, Last) William Keplinger						18. MOTHER'S NAME (First, Middle, Maiden Surname) Charlotte Miller									
19a. INFORMANT'S NAME (Type/Print) John Roberts						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Box D 2 Nikep, Md. 21546									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Laurel Hill Cemetery				20c. LOCATION — City or Town, State Barton Md.							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Wayne Boal						22. NAME AND ADDRESS OF FACILITY Boal-Warnick Funeral Home Westernport, Md. 21562									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Liver failure DUE TO (OR AS A CONSEQUENCE OF): b. Cirrhosis of liver DUE TO (OR AS A CONSEQUENCE OF): c. Hepatitis in remote past DUE TO (OR AS A CONSEQUENCE OF): d. Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST										Approximate Interval Between Onset and Death Long Standing					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal Failure: Arteriosclerosis Heart Disease and Congestive Failure										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										29b. SIGNATURE AND TITLE OF CERTIFIER SL Landrum MD		29c. LICENSE NUMBER D14464		29d. DATE SIGNED (Month, Day, Year) 2/14/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 48 Tarn Terrace Frostburg Md 21532															
31. DATE FILED (Month, Day, Year) FEB 19 1991				32. REGISTRAR'S SIGNATURE John Davidson-Randall											



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

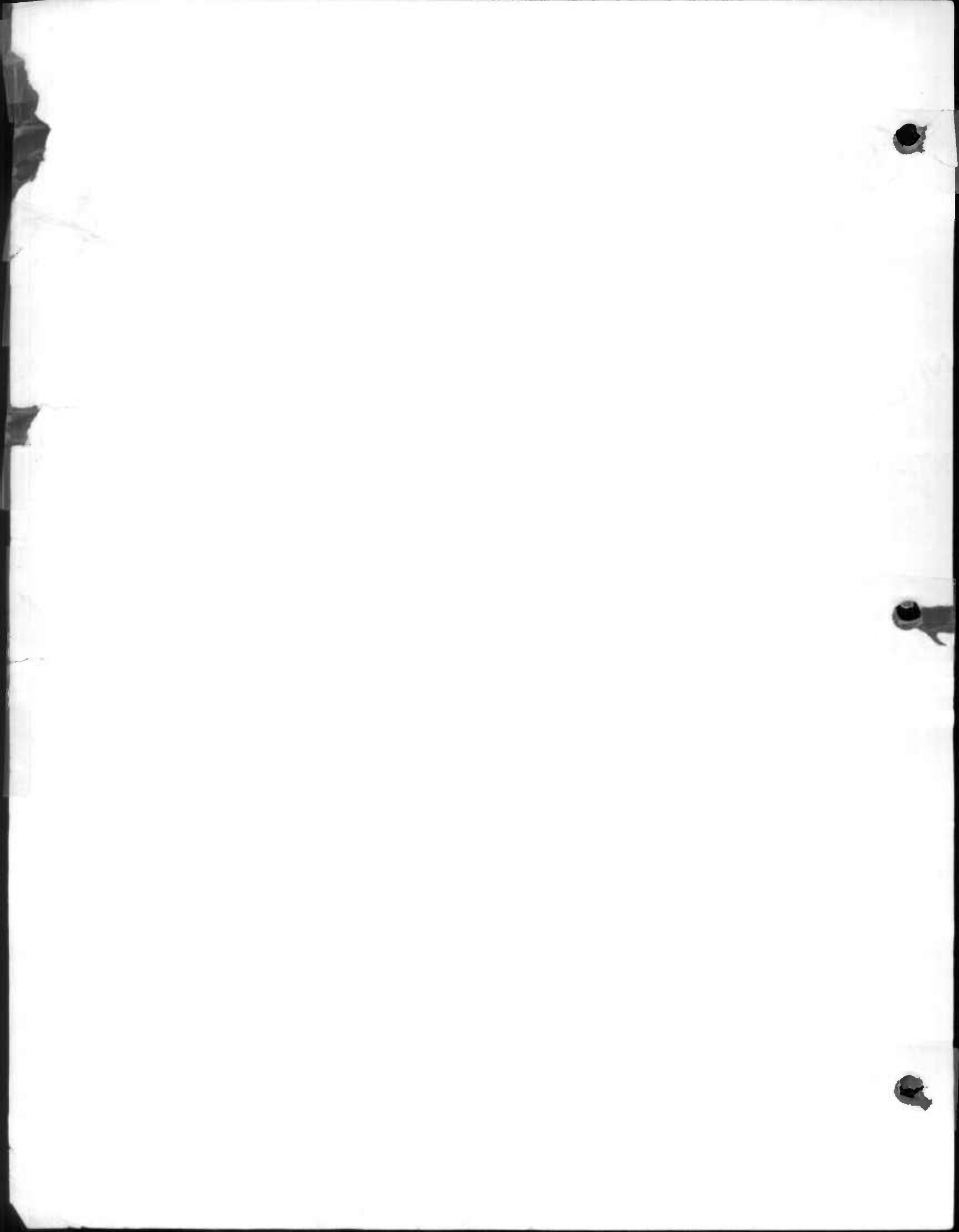
REG. NO.

91 05680

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) <b>Samuel Fordyce Stanley</b>				2. DATE OF DEATH MONTH DAY YEAR <b>Feb. 15, 1991</b>		3. TIME OF DEATH M <b>9:45</b>							
4. SOCIAL SECURITY NUMBER <b>140-01-7890</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>84</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Feb. 22, 1906</b>		8. BIRTHPLACE (State or Foreign Country) <b>Missouri</b>					
9a. FACILITY NAME (If not institution, give street and number) <b>4138 W. Leland Street</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Chevy Chase</b>				9c. COUNTY OF DEATH <b>Montgomery</b>					
10a. STATE <b>MD</b>		10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Chevy Chase</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
10e. STREET AND NUMBER <b>4138 Leland Street</b>				10f. ZIP CODE <b>20815</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Writer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Magazine</b>									
17. FATHER'S NAME (First, Middle, Last) <b>David Stanley</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Jane Fordyce</b>									
19a. INFORMANT'S NAME (Type/Print) <b>Emmy S. Stanley</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4138 Leland St., Chevy Chase, MD 20815</b>									
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Mt. Comfort Crematory</b>		20c. LOCATION — City or Town, State <b>Alexandria, VA</b>									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Michael E. Nelson</b>				22. NAME AND ADDRESS OF FACILITY <b>Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave., NW, Washington, D.C. 20016</b>									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>Metastatic Carcinoma</b> <b>Due to (or as a consequence of):</b> <b>Carcinoma of Throat and Pharynx</b> <b>Due to (or as a consequence of):</b> <b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> <b>Atrial fibrillation; Arteriosclerosis; Pernicious Anemia; Osteoarthritis.</b>								Approximate Interval Between Onset and Death <b>1 month</b> <b>13 months</b>					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Atrial fibrillation; Arteriosclerosis; Pernicious Anemia; Osteoarthritis.</b>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO		HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29b. SIGNATURE AND TITLE OF CERTIFIER <b>James S. J. MD</b>		29c. LICENSE NUMBER <b>6759</b>		29d. DATE SIGNED (Month, Day, Year) <b>Feb. 15, 1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Robert F. Dyer, M.D., 5530 Wisconsin Ave., Chevy Chase, MD 20815</b>													
31. DATE FILED (Month, Day, Year) <b>FEB 19 '91</b>		32. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>											



1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05681

1. DECEDENT'S NAME (First, Middle, Last) <b>Mary Eleanor Sullivan</b>				2. DATE OF DEATH MONTH DAY YEAR <b>FEB. 16, 1991</b>		3. TIME OF DEATH <b>8:40 A M</b>							
4. SOCIAL SECURITY NUMBER <b>577 03 0114</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>74</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>FEB. 15 1917</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>					
9a. FACILITY NAME (If not institution, give street and number) <b>Manor Care Nursing Home</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Wheaton</b>			9c. COUNTY OF DEATH <b>Montgomery</b>						
RESIDENCE OF DECEDENT				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Silver Spring</b>					
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>600 Cobblestone Court</b>		10f. ZIP CODE <b>20905</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 8+) <b>1</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Secretary</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Law Offices</b>									
17. FATHER'S NAME (First, Middle, Last) <b>James H. D. Ketner</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Willie P. Copp</b>									
19a. INFORMANT'S NAME (Type/Print) <b>Louise Knapman</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>600 Cobblestone Court, Silver Spring, MD 20905</b>									
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Columbia Gardens Cemetery</b>		20c. LOCATION — City or Town, State <b>Arlington, VA</b>									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>		22. NAME AND ADDRESS OF FACILITY <b>TAKOMA FUNERAL HOME, INC. 254 Carroll St. N.W. Washington DC</b>											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiopulmonary arrest</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):								Approximate Interval Between Onset and Death					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO		HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		26. PLACE OF DEATH (Check only one)		27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined					
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED							
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)											
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>		29c. LICENSE NUMBER <b>D 23170</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/17/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>GITA C. BAKHSHI M.D.</b>								31. DATE FILED (Month, Day, Year) <b>FEB 20 '91</b>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05682

1. DECEDENT'S NAME (First, Middle, Last) RALPH L. SNIDER				2. DATE OF DEATH MONTH DAY YEAR Feb. 16 1991				3. TIME OF DEATH 8:45 p.m.			
4. SOCIAL SECURITY NUMBER 234 03 5782		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 100 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 16 1890		8. BIRTHPLACE (State or Foreign Country) West Va.			
9a. FACILITY NAME (If not institution, give street and number) 14552 Cutstone Way				9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring				9c. COUNTY OF DEATH Montgomery			
10a. STATE Maryland			10b. COUNTY Montgomery			10c. CITY, TOWN OR LOCATION Silver Spring			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		
10e. STREET AND NUMBER 14552 Cutstone Way				10f. ZIP CODE 20905		10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Stock Foreman				16b. KIND OF BUSINESS/INDUSTRY Publishing House					
17. FATHER'S NAME (First, Middle, Last) William Snider				18. MOTHER'S NAME (First, Middle, Maiden Surname) Hattie							
19a. INFORMANT'S NAME (Type/Print) Eleanor M. Kelly				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14552 Cutstone Way, Silver Spring, MD 20905							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) George Washington Cemetery				20c. LOCATION — City or Town, State Adelphi, MD.					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE KENDALL BURNEY VANCIL <i>Kendall Burney Vancil</i>				22. NAME AND ADDRESS OF FACILITY TAKOMA FUNERAL HOME, INC. 254 Carroll St. N.W. Washington DC							
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Cardiac arrest</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Coronary artery disease</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death <i>immediate</i> <i>Yes</i>			
PART II: Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Advanced age (7100 yrs)</i>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Richard P. Delaney</i>						29c. LICENSE NUMBER D 02383		29d. DATE SIGNED (Month, Day, Year) 2/15/91			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Richard P. Delaney, M.D. 2415 Musgrove Rd. #209 Silver Spring, MD 20904											
31. DATE FILED (Month, Day, Year) FEB 20 '91				32. REGISTRAR'S SIGNATURE <i>James Davidson Randall</i>							



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05683

1. DECEDENT'S NAME (First, Middle, Last) <b>JAMES P. SUMMEROUR</b> <i>James P. Summerour</i>		2. DATE OF DEATH <b>FEB 13, 1991</b> <i>FEB 13, 1991</i>		3. TIME OF DEATH <b>8:25 PM</b> <i>8:25 PM</i>	
4. SOCIAL SECURITY NUMBER <b>316-44-8986</b> <i>316-44-8986</i>		5. SEX <b>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F</b>		6. AGE (In yrs. last birthday) <b>61 YRS.</b>	
7. DATE OF BIRTH (Month, Day, Year) <b>May 23, 1929</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>		9. CITY, TOWN OR LOCATION OF DEATH <b>Rockville</b>	
10. COUNTY OF DEATH <b>MONTGOMERY</b>		11. FACILITY NAME (If not institution, give street and number) <b>Shady Grove Adventist Hospital</b> <i>Shady Grove Adventist Hosp.</i>		12. RESIDENCE OF DECEDENT <b>616 Lincoln Street</b>	
13. STATE <b>Maryland</b>		14. COUNTY <b>Montgomery</b>		15. CITY, TOWN OR LOCATION <b>Rockville</b>	
16. INSIDE CITY LIMITS? <b>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO</b>		17. STREET AND NUMBER <b>616 Lincoln Street</b>		18. ZIP CODE <b>20850</b>	
19. CITIZEN OF WHAT COUNTRY? <b>USA</b>		20. MARITAL STATUS <b>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>		21. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO</b> IF YES, GIVE WAR OR DATES <b>Korean</b>	
22. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</b>		23. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>		24. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>12th</b>	
25. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Lab Technician</b>		26. KIND OF BUSINESS/INDUSTRY <b>US Government</b>		27. FATHER'S NAME (First, Middle, Last) <b>Sherman Summerour</b>	
28. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Ida Isreal</b>		29. INFORMANT'S NAME (Type/Print) <b>Lorretta A. Summerour</b> <i>(wife)</i>		30. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>616 Lincoln Street, Rockville, MD 20850</b>	
31. METHOD OF DISPOSITION <b>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>		32. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Lincoln Park Cemetery</b>		33. LOCATION — City or Town, State <b>Rockville, MD</b>	
34. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Cary R. Snowden</i>		35. NAME AND ADDRESS OF FACILITY <b>SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850</b>		36. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Obstructive lung disease</b> <i>obstructive lung disease</i> <b>Pneumectomy</b> <i>pneumectomy</i> <b>Lung cancer</b> <i>Lung cancer</i> <b>Cigarette smoking</b> <i>Cigarette smoking</i>	
37. IMMEDIATE CAUSE (Final disease or condition resulting in death) →		38. SEQUENTIALLY LIST CONDITIONS, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		39. APPROXIMATE Interval Between Onset and Death <b>one mo</b> <i>one mo</i> <b>one mo</b> <i>one mo</i> <b>three mo</b> <i>three mos</i> <b>40 yrs</b> <i>40 yrs</i>	
40. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>perforated viscous (stomach)</b> <i>necrotizing phlegmon</i>		41. WAS AN AUTOPSY PERFORMED? <b>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</b>		42. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO</b>	
43. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</b>		44. PLACE OF DEATH (Check only one) <b>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA</b> <b>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b>		45. MANNER OF DEATH <b>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined</b>	
46. DATE OF INJURY (Month, Day, Year) <b>28a.</b>		47. TIME OF INJURY <b>28b.</b>		48. INJURY AT WORK? <b>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO</b>	
49. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>28c.</b>		50. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>28d.</b>		51. DESCRIBE HOW INJURY OCCURRED <b>28e.</b>	
52. CERTIFIER (Check only one) <b>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>		53. SIGNATURE AND TITLE OF CERTIFIER <i>Alan R. Pollack</i>		54. LICENSE NUMBER <b>D 33443</b>	
55. DATE SIGNED (Month, Day, Year) <b>16 Feb 91</b>		56. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Alan R. Pollack MD 809 Viers Mill Rd Rockville 20851</b>		57. DATE FILED (Month, Day, Year) <b>FEB 19 '91</b>	
58. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>		59. REGISTRAR'S SIGNATURE			



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <i>William Conrad Stiner</i>				2. DATE OF DEATH MONTH <i>2</i> DAY <i>18</i> YEAR <i>91</i>		3. TIME OF DEATH <i>502 A M</i>	
4. SOCIAL SECURITY NUMBER <i>579-26-7046</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <i>66</i> YRS.	7. DATE OF BIRTH (Month, Day, Year) <i>Feb. 2, 1925</i>		8. BIRTHPLACE (State or Foreign Country) <i>Wash. DC</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Shady Grove Adventist Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Rockville</i>		9c. COUNTY OF DEATH <i>MONTGOMERY</i>	
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Montgomery</i>		10c. CITY, TOWN OR LOCATION <i>Gaithersburg</i>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <i>17653 Amity Drive</i>				10f. ZIP CODE <i>20877</i>		10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <i>Korean</i>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>11th</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Driver</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Montg. Co. Ride-on Bus</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Unknown</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Mildred Stiner</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Frances V. Hall</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>17653 Amity Drive, Gaithersburg, MD 20877</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Ash Memorial Cemetery</i>		20c. LOCATION — City or Town, State <i>Sandy Spring, MD</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George R. Snowden</i>				22. NAME AND ADDRESS OF FACILITY <i>SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Hepatic failure</i>  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. <i>Hepatic Failure</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Alcohol Abuse</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):						Approximate Interval Between Onset and Death <i>3 days</i> <i>7 mos</i>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Metabolic Acidosis - resolving</i>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28b. LOCATION (Street and Number or Rural Route Number, City or Town, State)		28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Wayne L. Meyer MD</i>				29c. LICENSE NUMBER <i>P 31840</i>		29d. DATE SIGNED (Month, Day, Year) <i>2/16/91</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Wayne L. Meyer MD 9715 Medical Center Drive, #214 Rockville, MD 20850</i>							
31. DATE FILED (Month, Day, Year) <i>FEB 19 '91</i>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			



91 05685

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Anna Mae Swann</b>				2. DATE OF DEATH MONTH <b>02</b> DAY <b>17</b> YEAR <b>91</b>		3. TIME OF DEATH <b>6:00 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>219-16-6739-A</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>80</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>3/6/10</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Great Laurel Beltsville Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Laurel, Maryland</b>	
9c. COUNTY OF DEATH <b>Prince George's</b>							
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Prince George</b>		10c. CITY, TOWN OR LOCATION <b>Beltsville</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>11500 Cordwall Drive</b>				10f. ZIP CODE <b>20705</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>3rd Grade</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Domestic</b>		16b. KIND OF BUSINESS/INDUSTRY <b>None</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Harry Johnson</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Unk.</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mrs Evelyn Matthews</b> (Daughter)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11500 Cordwall Drive, Beltsville, Md 20705</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>St James Meth Church Cem.</b>		20c. LOCATION — City or Town, State <b>Jarrettsville, Md</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George R. Snowden</i>				22. NAME AND ADDRESS OF FACILITY <b>SNOWDEN FUNERAL HOME P.A. 20850 246 N. Washington St, Rockville, Md</b>			
23. PART I. Enter the disease(s), or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>CARDIO - PULMONARY ARREST</b> <b>Cardio-pulmonary Arrest</b> IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) <input checked="" type="checkbox"/> HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Julia Davidson-Randall</i>				29c. LICENSE NUMBER <b>025136</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/17/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>14201 Laurel Park Drive, Suite 214, Laurel, Md. 20707</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 19 '91</b>		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





## REG NO

DMMH-18 Rev 1/89

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

*Handwritten signature or scribble*

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05687

1. DECEDENT'S NAME (First, Middle, Last) <b>BARBARA LOUISE SEITER</b>				2. DATE OF DEATH MONTH <b>2</b> DAY <b>16</b> YEAR <b>91</b>		3. TIME OF DEATH <b>0535 A</b>	
4. SOCIAL SECURITY NUMBER <b>092-22-0633</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>87</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>5/28/1903</b>	
8. BIRTHPLACE (State or Foreign Country) <b>New York</b>				9a. FACILITY NAME (If not institution, give street and number) <b>SHADY GROVE ADVENTIST HOSPITAL</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Rockville,</b>	
9c. COUNTY OF DEATH <b>Montgomery</b>				10a. STATE <b>Florida</b>		10b. COUNTY <b>Dade</b>	
10c. CITY, TOWN OR LOCATION <b>Miami</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>11324 S.W. 172nd. Street</b>	
10f. ZIP CODE <b>33157</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 8+) <b>College</b>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Civil Servant</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Local Government</b>			
17. FATHER'S NAME (First, Middle, Last) <b>William Wubbenhurst</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Gertrude Schurter</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Carol Steadman</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>20688 Highland Hall Dr. Gaithersburg Md. 20879</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metropolitan Crematory</b>		20c. LOCATION — City or Town, State <b>Alexandria, Virginia</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSE <b>J.E. Ball</b> <b>M00896</b>				22. NAME AND ADDRESS OF FACILITY <b>DeVol Funeral Home</b> <b>10 E. Deer Park Dr. Gaithersburg, MD 20877</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Cardio - Respir arrest</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>b. Cerebral Infarction</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c. Cerebral Thrombosis</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d. Generalized arteriosclerosis</b>						Approximate Interval Between Onset and Death <b>20'</b> <b>5 days</b> <b>5 days</b> <b>10 years</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Arteriosclerotic Cardio-vascular Disease</b> <b>Hypertension - ventricular ectopy</b> <b>Coronary Heart Failure</b>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO						25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined	
28a. DATE OF INJURY (Month, Day, Year)						28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Stephen W. Jones</b>						29c. LICENSE NUMBER	
29d. DATE SIGNED (Month, Day, Year) <b>2/16/91</b>						30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Stephen W. Jones, MD - 809 Viers Mill Rd. Rockville, Md 20857</b>	
31. DATE FILED (Month, Day, Year) <b>FEB 19 '91</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, and 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last) <b>Anne B. Settle</b>				2. DATE OF DEATH MONTH <b>02</b> - DAY <b>11</b> - YEAR <b>91</b>	
4. SOCIAL SECURITY NUMBER <b>075-16-7089</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>70</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>SEPT. 4, 1920</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>BALTIMORE COUNTY GENERAL HOSPITAL</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		9c. COUNTY OF DEATH <b>BALTIMORE</b>	
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>MONTGOMERY</b>		10c. CITY, TOWN OR LOCATION <b>WHEATON</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>706 KENBROOK DRIVE</b>		10f. ZIP CODE <b>20902</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (14 or 5+) <b>4</b>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>REGISTERED NURSE</b>		16b. KIND OF BUSINESS/INDUSTRY <b>MEDICAL</b>		17. FATHER'S NAME (First, Middle, Last) <b>BERTHOLD BAKKER</b>	
18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>GRACE CHADWICK</b>		19a. INFORMANT'S NAME (Type/Print) <b>GRACE S. CRICKMAN (DAUGHTER)</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7343 ARGONNE DRIVE, MARIOTTSTVILLE, MARYLAND 21104</b>	
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>METROPOLITAN CREMATORY</b>		20c. LOCATION — City or Town, State <b>ALEXANDRIA, VIRGINIA</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>James E. Dooley</b>		22. NAME AND ADDRESS OF FACILITY <b>FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W., SIL.SP., MD 20901</b>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Bilateral pneumonia / sepsis</u></b> <b>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> <b><u>Coronary artery disease</u></b> <b><u>Parkinsonism</u></b> <b><u>Multiple contractures</u></b>	
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO		25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <b>2/11/91</b>	
28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Julia Davidson-Randall</b>		29c. LICENSE NUMBER <b>D38882</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/11/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>KHALID K. AL-TALIB, Baltimore County General Hospital</b>					
31. DATE FILED (Month, Day, Year) <b>2/11/91</b>		32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			



91 05689

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>GRACE MIRIAM STOPSACK</b>				2. DATE OF DEATH MONTH <b>2</b> DAY <b>10</b> YEAR <b>91</b>		3. TIME OF DEATH <b>6:25 PM</b>	
4. SOCIAL SECURITY NUMBER <b>220-44-2996</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>100</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>NOV. 8, 1890</b>	
8. BIRTHPLACE (State or Foreign Country) <b>WASHINGTON, D.C.</b>				9a. FACILITY NAME (If not institution, give street and number) <b>SUBURBAN HOSPITAL</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BETHESDA</b>	
9c. COUNTY OF DEATH <b>MONTGOMERY</b>				10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>MONTGOMERY</b>	
10c. CITY, TOWN OR LOCATION <b>KENSINGTON</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>3513 RAYMOOR ROAD</b>	
10f. ZIP CODE <b>20895</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>HOUSEWIFE</b>			
16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOUSEWIFE</b>				16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>ALEXANDER M. FAIRBANK</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>FLORENCE E. WALTERS</b>			
19a. INFORMANT'S NAME (Type/Print) <b>NORMAN MUMAW</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3513 RAYMOOR ROAD KENSINGTON, MARYLAND 20895</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>CEDAR HILL CEMETERY</b>			
20c. LOCATION — City or Town, State <b>SUITLAND, MARYLAND</b>				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Francis J. Collins</i>			
22. NAME AND ADDRESS OF FACILITY <b>FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W. SIL. SPR., MD. 20901</b>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Congestive Heart Failure</b>  Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Arteriosclerotic Heart Disease</b>  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Fractured Hip</b>			
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) <b>2-8-91</b>			
28b. TIME OF INJURY <b>6:00 PM</b>				28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED <b>Fell</b>				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>Nursing Home</b>			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>8700 Jones Mill Rd</b>				29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John Vander</i>				29c. LICENSE NUMBER <b>208546</b>			
29d. DATE SIGNED (Month, Day, Year) <b>2-11-91</b>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>John Vander 8212 Wisconsin Ave Bethesda Md.</b>			
31. DATE FILED (Month, Day, Year) <b>FEB 14 '91</b>				32. REGISTRAR'S SIGNATURE <i>Gisha Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				CERTIFICATE OF DEATH		REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last) <i>Mary T. Smith</i>				2. DATE OF DEATH MONTH <i>02</i> DAY <i>13</i> YEAR <i>91</i>		3. TIME OF DEATH <i>9:14 P M</i>			
4. SOCIAL SECURITY NUMBER <i>021-12-4353</i>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>69</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>08-26-21</i>		8. BIRTHPLACE (State or Foreign Country) <i>USA</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Holy Cross Hospital 1500 Forest Glen Rd.</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Silver Spring Md 20910</i>		9c. COUNTY OF DEATH <i>Montgomery</i>			
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Prince Georges</i>		10c. CITY, TOWN OR LOCATION <i>Takoma Park</i>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER <i>1006 Hopewell Avenue</i>				10f. ZIP CODE <i>20912</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>1</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Homemaker</i>		16b. KIND OF BUSINESS/INDUSTRY <i>At Home</i>					
17. FATHER'S NAME (First, Middle, Last) <i>Christopher Nolan</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Anna Hendrick</i>					
19a. INFORMANT'S NAME (Type/Print) <i>Kathleen M. Smith</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1006 Hopewell Avenue, Takoma Park MD 20912</i>					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Fort Lincoln Cemetery</i>		20c. LOCATION — City or Town, State <i>Brentwood, MD</i>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Deanne S. Clark</i>				22. NAME AND ADDRESS OF FACILITY <i>TAKOMA FUNERAL HOME, INC. 254 Carroll St. NW Washington DC</i>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>INTRACEREBRAL HEMORRHAGE</i> DUE TO (OR AS A CONSEQUENCE OF): <i>STROKE</i> DUE TO (OR AS A CONSEQUENCE OF): <i>CEREBROVASCULAR ARTERIOSCLEROTIC OCCLUSIVE DISEASE</i> DUE TO (OR AS A CONSEQUENCE OF):  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>CIGARRETTE SMOKING</i> <i>HYPERTENSION</i>								Approximate interval Between Onset and Death <i>14 days</i> <i>14 days</i> <i>3 YEARS</i>	
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Deanne S. Clark MD</i>		29c. LICENSE NUMBER <i>021153</i>		29d. DATE SIGNED (Month, Day, Year) <i>2/14/91</i>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>GARRY D. RUBEN, 1120 NEW HAMP AVE. SILVER SPRING, MD 20904</i>									
31. DATE FILED (Month, Day, Year) <i>FEB 15 '91</i>		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>							



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 7 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05691

1. DECEDENT'S NAME (First, Middle, Last) Ray Silverman		2. DATE OF DEATH MONTH DAY YEAR 02-19-91		3. TIME OF DEATH 4:34 A.M.	
4. SOCIAL SECURITY NUMBER 213-20-3651		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		8. AGE (In yrs. last birthday) 72	
9a. FACILITY NAME (If not institution, give street and number) Anne Arundel Medical Center		9b. CITY, TOWN OR LOCATION OF DEATH Annapolis		9c. COUNTY OF DEATH Anne Arundel	
10a. STATE MD		10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Annapolis	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 680 Americana Drive - A-4		10f. ZIP CODE 21403	
10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 10	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Retail Sales		16b. KIND OF BUSINESS/INDUSTRY Automotive		17. FATHER'S NAME (First, Middle, Last) Louis Silverman	
18. MOTHER'S NAME (First, Middle, Maiden Surname) Ida Evnin		19a. INFORMANT'S NAME (Type/Print) Stuart Silverman		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 680 Americana Dr., A4, Annapolis, MD	
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Hillcrest Cemetery		20c. LOCATION — City or Town, State Annapolis, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Pat J. [Signature]</i>		22. NAME AND ADDRESS OF FACILITY Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Cardiac arrest</i>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <i>Coronary artery disease</i> c. <i>ASCVD</i> d.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Co PD</i>	
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
26. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Other (Specify)		27. DATE OF INJURY (Month, Day, Year) 28. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
29a. CERTIFIER (Check only one) 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>		29c. LICENSE NUMBER 023-142	
29d. DATE SIGNED (Month, Day, Year) 2/19/91		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SAUD KRICMAS, M.D. 25 SHAW ST. ANNAPOLIS, MD 21404		31. DATE FILED (Month, Day, Year) FEB 20 1991	
32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				CERTIFICATE OF DEATH				REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last) Babette K. Schutt						2. DATE OF DEATH MONTH DAY YEAR 02-17-91				3. TIME OF DEATH M					
4. SOCIAL SECURITY NUMBER 090-22-2267		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 83 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) 11-02-07		8. BIRTHPLACE (State or Foreign Country) Germany			
9a. FACILITY NAME (If not institution, give street and number) 115 Staton Drive						9b. CITY, TOWN OR LOCATION OF DEATH Upper Marlboro				9c. COUNTY OF DEATH Prince George					
RESIDENCE OF DECEDENT															
10a. STATE MD		10b. COUNTY Prince George		10c. CITY, TOWN OR LOCATION Upper Marlboro						10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
10e. STREET AND NUMBER 115 Staton Drive				10f. ZIP CODE 20770				10g. CITIZEN OF WHAT COUNTRY? USA							
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White									
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife				16b. KIND OF BUSINESS/INDUSTRY Household							
17. FATHER'S NAME (First, Middle, Last) Frederick Ehrmann						18. MOTHER'S NAME (First, Middle, Maiden Surname) Koraline Hillermayer									
19a. INFORMANT'S NAME (Type/Print) Joseph Schutt				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 115 Staton Dr. Upper Marlboro, MD											
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Flushing Cemetery				20c. LOCATION — City or Town, State Queens, NY							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Patricia J. Smith</i>				22. NAME AND ADDRESS OF FACILITY Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Removal of uterus</i>  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF): <i>uterine cancer</i> b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):										Approximate Interval Between Onset and Death					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										29b. SIGNATURE AND TITLE OF CERTIFIER <i>Sharon C. Crum</i>		29c. LICENSE NUMBER D39456		29d. DATE SIGNED (Month, Day, Year) 2/18/90	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)															
31. DATE FILED (Month, Day, Year) FEB 19 1991				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>											



91 05693

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Helen Marie Spangler</b>				2. DATE OF DEATH MONTH DAY YEAR <b>Feb. 16, 1991</b>		3. TIME OF DEATH <b>0805 hr M</b>	
4. SOCIAL SECURITY NUMBER <b>215-30-0056</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>56</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>May 17, '34</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>St. Agnes Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>	
9c. COUNTY OF DEATH <b>Baltimore</b>				10a. STATE <b>MD</b>			
10b. COUNTY <b>Anne Arundel</b>				10c. CITY, TOWN OR LOCATION <b>Millersville</b>			
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>1323 Ashburton Drive</b>			
10f. ZIP CODE <b>21108</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Household</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Leonard Wrzesinski</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Clara Milwicz</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Neil A. Spangler</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1323 Ashburton Dr. Millersville, MD 21108</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Glen Haven Cemetery</b>		20c. LOCATION — City or Town, State <b>Glen Burnie, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Barth A. [Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>Hardesty Funeral Home, P.A. 851 Annapolis Road, Gambrills, MD</b>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acute Cerebral Hemorrhage</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>Metastatic Malignant Melanoma</b> DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):						Approximate Interval Between Onset and Death <b>8 days</b> <b>28 months</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.     						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Jeffrey Sagel DO</i>				29c. LICENSE NUMBER <b>H 40961</b>		29d. DATE SIGNED (Month, Day, Year) <b>Feb 16, 1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Jeffrey Sagel DO 96 St Agnes Hospital 900 Caton Ave. Baltimore MD 21229</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 19 1991</b>				32. REGISTRAR'S SIGNATURE <i>Jane Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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COLLOID ELECTROLYTE

Electrolyte Solution

502



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, and 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				91 05694			
1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH				3. TIME OF DEATH			
William V. Stallings				Feb. 14 1991				M			
4. SOCIAL SECURITY NUMBER		5. SEX		8. AGE (In yrs. last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		7. DATE OF BIRTH	
579-07-1232		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		75 YRS.		MONTHS DAYS HOURS MIN.		8-28-1915		8. BIRTHPLACE (State or Foreign Country)	
9a. FACILITY NAME (If not institution, give street and number)				9b. CITY, TOWN OR LOCATION OF DEATH				9c. COUNTY OF DEATH			
Anne Arundel Medical Ctr.				Annapolis				Anne Arundel			
RESIDENCE OF DECEDENT				10a. STATE				10b. COUNTY			
Md.				Anne Arundel				10c. CITY, TOWN OR LOCATION			
14 Constitution Avenue				21401				10d. INSIDE CITY LIMITS?			
10e. STREET AND NUMBER				10f. ZIP CODE				10g. CITIZEN OF WHAT COUNTRY?			
14 Constitution Avenue				21401				USA			
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES?		13. WAS DECEDENT OF HISPANIC ORIGIN?		14. RACE — American Indian, Black, White, etc.		15. DECEDENT'S EDUCATION		16a. DECEDENT'S USUAL OCCUPATION	
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		Specify: White		Elementary/Secondary (0-12) College (1-4 or 5+)		Foreman	
15. DECEDENT'S EDUCATION		16b. KIND OF BUSINESS/INDUSTRY		17. FATHER'S NAME (First, Middle, Last)		18. MOTHER'S NAME (First, Middle, Maiden Surname)		19a. INFORMANT'S NAME (Type/Print)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
Elementary/Secondary (0-12) College (1-4 or 5+)		Steel Manufacturing		Gordon Stallings		UNKNOWN		Ruth V. Stallings		14 Constitution Ave. Annapolis, Md. 21401	
20a. METHOD OF DISPOSITION		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)		20c. LOCATION — City or Town, State		21. SIGNATURE OF FUNERAL SERVICE LICENSEE		22. NAME AND ADDRESS OF FACILITY		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		Hillcrest Cemetery		Annapolis, Md.		Jeffrey S. Layla		Taylor Funeral Chapel Annapolis, Md.		IMMEDIATE CAUSE (Final disease or condition resulting in death) →	
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		Hillcrest Cemetery		Annapolis, Md.		Jeffrey S. Layla		Taylor Funeral Chapel Annapolis, Md.		a. Cordis pulmonary Arrest	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE		22. NAME AND ADDRESS OF FACILITY		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.		24a. WAS AN AUTOPSY PERFORMED?		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		Approximate Interval Between Onset and Death	
Jeffrey S. Layla		Taylor Funeral Chapel Annapolis, Md.		IMMEDIATE CAUSE (Final disease or condition resulting in death) →		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		30 m.	
24a. WAS AN AUTOPSY PERFORMED?		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEATH (Check only one)		27. MANNER OF DEATH	
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		COPD		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> Other (Specify)		1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	
25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEATH (Check only one)		27. MANNER OF DEATH		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK?	
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> Other (Specify)		1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK?		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER	
28a. DATE OF INJURY (Month, Day, Year)											



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.					
1. DECEDENT'S NAME (First, Middle, Last) <b>EDWINA SNOW</b>						2. DATE OF DEATH MONTH DAY YEAR <b>FEBRUARY 14, 1991</b>		3. TIME OF DEATH <b>1:45 A</b> M					
4. SOCIAL SECURITY NUMBER <b>053-24-9576</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>63</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>7/14/27</b>		8. BIRTHPLACE (State or Foreign Country) <b>NY</b>					
9a. FACILITY NAME (If not institution, give street and number) <b>PENINSULA GENERAL HOSPITAL</b>						9b. CITY, TOWN OR LOCATION OF DEATH <b>SALISBURY</b>			9c. COUNTY OF DEATH <b>WICOMICO</b>				
10a. STATE <b>MD</b>		10b. COUNTY <b>Talbot</b>		10c. CITY, TOWN OR LOCATION <b>Oxford</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO					
10e. STREET AND NUMBER <b>103 N. Morris Street</b>				10f. ZIP CODE <b>21654</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>1</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Publisher</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Publishing</b>					
17. FATHER'S NAME (First, Middle, Last) <b>Edwin Christian Feigenspan</b>						18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Flora Ross</b>							
19a. INFORMANT'S NAME (Type/Print) <b>MacVicker Snow</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>103 N. Morris Street Oxford, MD 21654</b>									
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Eastern Shore Crematory</b>				20c. LOCATION — City or Town, State <b>Georgetown, DE</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>M. E. Newman</b> CFSP				22. NAME AND ADDRESS OF FACILITY <b>Newnam Funeral Home 200 S. Harrison Street Easton, MD</b>									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Metastatic Breast Cancer</b>  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF):  b. DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d.										Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED			
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER <b>David E. Cowall, MD</b>						29c. LICENSE NUMBER <b>026278</b>		29d. DATE SIGNED (Month, Day, Year) <b>2-14-91</b>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>David E. Cowall, MD, 145 E. Carroll St. Salisbury, MD 21801</b>													
31. DATE FILED (Month, Day, Year) <b>FEB 19 91</b>				32. REGISTRAR'S SIGNATURE <b>Julia K. Anderson</b>									



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05696

1. DECEDENT'S NAME (First, Middle, Last) <b>Harry Hitchens Schwartz</b>				2. DATE OF DEATH MONTH <b>2</b> DAY <b>15</b> YEAR <b>91</b>		3. TIME OF DEATH <b>3:47 A.M.</b>							
4. SOCIAL SECURITY NUMBER <b>550-26-8998</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>76 YRS.</b>		7. DATE OF BIRTH (Month, Day, Year) <b>11/8/14</b>		8. BIRTHPLACE (State or Foreign Country) <b>OHIO</b>					
9a. FACILITY NAME (If not institution, give street and number) <b>Memorial Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Easton</b>				9c. COUNTY OF DEATH <b>Talbot</b>					
10a. STATE <b>MD</b>		10b. COUNTY <b>Talbot</b>		10c. CITY, TOWN OR LOCATION <b>Easton</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
10e. STREET AND NUMBER <b>R.D. #4, Box 444</b>				10f. ZIP CODE <b>21601</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>U.S. Foreign Service</b>				18b. KIND OF BUSINESS/INDUSTRY							
17. FATHER'S NAME (First, Middle, Last) <b>Harry James Schwartz</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Marguerite Hitchens</b>									
19a. INFORMANT'S NAME (Type/Print) <b>Maria Schwartz</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>R.D. #4, Box 444 Easton, MD 21601</b>									
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Eastern Shore Crematory</b>		DATE <b>2/15/91</b>		20c. LOCATION — City or Town, State <b>Georgetown, DE</b>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>M. E. Newman C.F.S.P.</b>				22. NAME AND ADDRESS OF FACILITY <b>Newnam Funeral Home 200 S. Harrison Easton, MD 21601</b>									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>Diffuse Interstitial pneumonia</b> <b>INFLUENZA</b> <b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> <b>SCORDED PROFOUND DERMATITIS</b> <b>ANGINA</b>								Approximate Interval Between Onset and Death <b>WK.</b>					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>SCORDED PROFOUND DERMATITIS</b> <b>ANGINA</b>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>Scott D. Friedman MD</b>		29c. LICENSE NUMBER <b>D23962</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/15/91</b>							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Scott D. Friedman, MD 403 Marvel Court Easton, MD 21601</b>													
31. DATE FILED (Month, Day, Year) <b>FEB 19 '91</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>									



91 05697

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>GEORGE ALBERT SEYMOUR SR.</b>						2. DATE OF DEATH MONTH DAY YEAR <b>Feb. 7, 1991</b>		3. TIME OF DEATH <b>1:10 A. M</b>	
4. SOCIAL SECURITY NUMBER <b>212-09-4651</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>93</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) <b>Nov. 9, 1897</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Meridian Center the Pines</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Easton</b>			9c. COUNTY OF DEATH <b>Talbot</b>		
RESIDENCE OF DECEDENT									
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Talbot</b>		10c. CITY, TOWN OR LOCATION <b>St. Michaels</b>			10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER <b>1103 Riverview Terrace</b>				10f. ZIP CODE <b>21663</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>Union Trust Bank</b>			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Banking Branch Manager</b>			16b. KIND OF BUSINESS/INDUSTRY <b>Banking Branch Manager</b>			
17. FATHER'S NAME (First, Middle, Last) <b>George A. Seymour</b>					18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Lucy Freeman</b>				
19a. INFORMANT'S NAME (Type/Print) <b>George A. Seymour Jr.</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1103 Riverview Terrace St. Michaels, Md. 21663</b>					
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Olivet Cemetery</b>			20c. LOCATION — City or Town, State <b>St. Michaels, Md.</b>				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Harrison E. Leonard</i>				22. NAME AND ADDRESS OF FACILITY <b>Harrison E. Leonard Funeral Home 312 S. Talbot St. St. Michaels, Md. 21663</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cerebral Vascular Catastrophe</i>  Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <i>Intermittent Cardiac Disease</i>  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):								Approximate Interval Between Onset and Death <i>2 wks.</i> <i>years.</i>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29c. SIGNATURE AND TITLE OF CERTIFIER <i>R. Lane Wroth</i>						29d. LICENSE NUMBER <b>D11308</b>		29e. DATE SIGNED (Month, Day, Year) <b>7-7-91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>R. Lane Wroth M.D. 800 S. Talbot St. St. Michaels, Maryland 21663</b>									
31. DATE FILED (Month, Day, Year) <b>FEB - 8 '91</b>				32. REGISTRAR'S SIGNATURE <i>John A. ...</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





91 05698

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>LOLA ELLEN SNYDER</b>				2. DATE OF DEATH MONTH DAY YEAR <b>February 19, 1991</b>		3. TIME OF DEATH <b>8:00 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>217-48-2556</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>107</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>11-26-1883</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Coffman Nursing Home</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Hagerstown</b>	
9c. COUNTY OF DEATH <b>Washington</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Washington</b>	
10c. CITY, TOWN OR LOCATION <b>Boonsboro</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>Rfd. 1</b>	
10f. ZIP CODE <b>21713</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8 yrs.</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Residence</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Robert Emory Shafer</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Martha Ellen Shafer</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Catherine McCauley</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1525 Dual Highway Hagerstown, Maryland 21740</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Benevola Cemetery 2-22-1991</b>		20c. LOCATION — City or Town, State <b>Benevola, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Douglas A. Fiery</b>				22. NAME AND ADDRESS OF FACILITY <b>Bast Funeral Home 7606 Boonsboro Pike Boonsboro, Maryland</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Coronary Heart Failure</b>							
a. DUE TO (OR AS A CONSEQUENCE OF):							
b. <b>Arteriosclerotic Heart Disease</b>							
c. <b>Coronary Arteriosclerosis</b>							
d.							
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Advanced Age (107 yrs)</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Y. Packer M.D.</b>				29c. LICENSE NUMBER <b>D09930</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/20/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Lawrence L. Packer Jr. M.D. 145 West Washington St. Hagerstown, Maryland 21740</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 21 '91</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05699

1. DECEDENT'S NAME (First, Middle, Last) Marion Clesetine St. Denis				2. DATE OF DEATH MONTH DAY YEAR Feb. 21, 1991		3. TIME OF DEATH 10:00 a. m.	
4. SOCIAL SECURITY NUMBER 101-28-5795 B		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 82 YRS.	7. DATE OF BIRTH (Month, Day, Year) May 19, 1908		8. BIRTHPLACE (State or Foreign Country) New York	
9a. FACILITY NAME (If not institution, give street and number) 42 Woodcrest Avenue				9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown		9c. COUNTY OF DEATH Washington	
10a. STATE Maryland		10b. COUNTY Washington		10c. CITY, TOWN OR LOCATION Hagerstown		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 42 Woodcrest Avenue				10f. ZIP CODE 21740		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 years College (1-4 or 5+) 2 years		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) homemaker		16b. KIND OF BUSINESS/INDUSTRY home			
17. FATHER'S NAME (First, Middle, Last) Thomas Francis McGuire				18. MOTHER'S NAME (First, Middle, Maiden Surname) Theresa Mary Fagan			
19a. INFORMANT'S NAME (Type/Print) Francis T. St. Denis				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 42 Woodcrest Avenue Hagerstown, Maryland 21740			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) St. Mary's Cemetery		20c. LOCATION — City or Town, State Suracuse, New York			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Gerald N. Minnich</i>				22. NAME AND ADDRESS OF FACILITY Gerald N. Minnich Funeral Home 305 N. Potomac Street Hagerstown, Maryland			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>cardiac arrest</i> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>severe dementia</i>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER D3256		29d. DATE SIGNED (Month, Day, Year) 2-21-91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Robert . Guedenet 100 Greeting Lane Keedysville, Maryland 21756							
31. DATE FILED (Month, Day, Year) FEB 25 '91		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2 & 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 05700

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>BREMA CATHLEEN SPONAUGLE</b>				2. DATE OF DEATH MONTH <b>02</b> DAY <b>17</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>19:25 P M</b>	
4. SOCIAL SECURITY NUMBER <b>219-03-9395</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>81</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>MAY 16, 1909</b>	
8. BIRTHPLACE (State or Foreign Country) <b>WEST VIRGINIA</b>				9a. FACILITY NAME (If not institution, give street and number) <b>SACRED HEART HOSPITAL</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>CUMBERLAND, MARYLAND</b>	
9c. COUNTY OF DEATH <b>ALLEGANY</b>				10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>ALLEGANY</b>	
10c. CITY, TOWN OR LOCATION <b>CUMBERLAND</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>709 FAYETTE STREET</b>	
10f. ZIP CODE <b>21502</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b></b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>WORKER-CONING DEPT.</b>		16b. KIND OF BUSINESS/INDUSTRY <b>CELANESE CORPORATION</b>	
17. FATHER'S NAME (First, Middle, Last) <b>HOWARD CECIL LAFFERTY</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>EFFIE L. BEAVERS</b>			
19a. INFORMANT'S NAME (Type/Print) <b>LYDIA LORRAINE ORT</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>415-1/2 HOLLAND ST-CUMBERLAND, MD 21502</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>OMPS CREMATORY</b>		20c. LOCATION — City or Town, State <b>2-19-91 WINCHESTER, VA</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George Upchurch</i>				22. NAME AND ADDRESS OF FACILITY <b>GEORGE-UPCHURCH FUNERAL HOME, P.A. CUMBERLAND, MARYLAND 21502</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Respiratory failure with pulmonary edema</i>							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <i>Coronary heart failure - acute</i>							
DUE TO (OR AS A CONSEQUENCE OF):							
c. <i>Coronary heart failure - chronic</i>							
DUE TO (OR AS A CONSEQUENCE OF):							
d. <i>Renal failure</i>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>James R. Moen MD</i>				29c. LICENSE NUMBER <b>D33417 (MD)</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/18/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>1068 National Ave - ROAN LAVALLE, MD 21502</b>							
31. DATE FILED (Month, Day, Year) <b>2/19/91 FEB 19 1991</b>				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

18. 10. 1917

18. 10. 1917

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05701

1. DECEDENT'S NAME (First, Middle, Last) ARTHUR J. SMITH, I				2. DATE OF DEATH MONTH DAY YEAR February 16, 1991		3. TIME OF DEATH 3:05 P M				
4. SOCIAL SECURITY NUMBER 214-07-3418		5. SEX XX M 2 F		8. AGE (In yrs. last birthday) 76 YRS.		7. DATE OF BIRTH (Month, Day, Year) 09-27-1914		8. BIRTHPLACE (State or Foreign Country) MD		
9a. FACILITY NAME (If not institution, give street and number) Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Cumberland			9c. COUNTY OF DEATH Allegany			
10a. STATE WV		10b. COUNTY Mineral		10c. CITY, TOWN OR LOCATION Keyser,			10d. INSIDE CITY LIMITS? 1 YES 2 NO			
10e. STREET AND NUMBER Route 2 Box 193				10f. ZIP CODE 26726		10g. CITIZEN OF WHAT COUNTRY? USA				
11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced XX Married		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO			14. RACE — American Indian, Black, White, etc. Specify: white			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) retired			16b. KIND OF BUSINESS/INDUSTRY Textile			
17. FATHER'S NAME (First, Middle, Last) Joseph A. Smith				18. MOTHER'S NAME (First, Middle, Maiden Surname) Teresa Wright						
19a. INFORMANT'S NAME (Type/Print) Mrs. Ethel F. Smith				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Route 2 Box 193 Keyser, WV 26726						
20a. METHOD OF DISPOSITION XX Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Sunset Memorial Park			20c. LOCATION — City or Town, State Cumberland, MD					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE James F. Scarpelli				22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home Cumberland, MD 21502						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → acute arterial occlusion right leg Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Renal Failure c. Chronic Myeloid Leukemia							Approximate Interval Between Onset and Death 6 DAYS ? 7 months			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)								
27. MANNER OF DEATH 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 YES 2 NO		28d. DESCRIBE HOW INJURY OCCURRED		
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER Phillip J. Schroeder MD						29c. LICENSE NUMBER D17456		29d. DATE SIGNED (Month, Day, Year) 2/18/91		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr Phillip Schroeder Memorial Hospital Cumberland, Md. 21502										
31. DATE FILED (Month, Day, Year) FEB 19 1991										

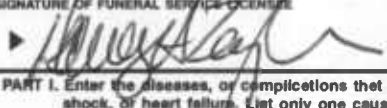

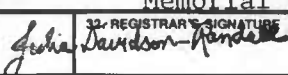




91 05702

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>EDITH OMEGA SUDER</b>				2. DATE OF DEATH MONTH DAY YEAR <b>February 15, 1991</b>		3. TIME OF DEATH <b>7:38P</b>	
4. SOCIAL SECURITY NUMBER <b>236-20-9421</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) <b>95</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>08/20/95</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Memorial Hospital &amp; Medical Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Cumberland</b>		9c. COUNTY OF DEATH <b>Allegany</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MD</b>		10b. COUNTY <b>ALLEGANY</b>		10c. CITY, TOWN OR LOCATION <b>CORRIGANVILLE</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>SUDER'S LANE, P O BOX 78</b>				10f. ZIP CODE <b>21524</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOMEMAKER</b>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>NOAH M. JENKIN</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MARY REBECCA TROUTMAN</b>			
19a. INFORMANT'S NAME (Type/Print) <b>GENEVIEVE M. SUDER</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P O BOX 78, CORRIGANVILLE, MD 21524</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>RESTLAWN MEMORIAL GARDENS</b>		20c. LOCATION — City or Town, State <b>LA VALE, MARYLAND</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY <b>HARVEY H. ZEIGLER FUNERAL HOME HYNDMAN, PA 15545-0636</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardio-Respiratory Arrest</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { a. <b>Cervical Contusion</b> b. <b>Syncope</b> c. <b>Organic Brain Syndrome</b> d. <b>Organic Brain Syndrome</b>							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D23371</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/16/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Zaman Memorial Hospital Medical Building, Cumberland, MD 21502</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 19 1991</b>		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 05703

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <u>James Edward Thomas</u>		2. DATE OF DEATH MONTH <u>2</u> DAY <u>14</u> YEAR <u>91</u>		3. TIME OF DEATH <u>0030</u> M	
4. SOCIAL SECURITY NUMBER <u>579-30-3341</u>	5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <u>62</u> YRS.	7. DATE OF BIRTH (Month, Day, Year) <u>9-23-28</u>	8. BIRTHPLACE (State or Foreign Country) <u>Maryland</u>	
9a. FACILITY NAME (If not institution, give street and number) <u>Washington Adventist Hospital</u>		9b. CITY, TOWN OR LOCATION OF DEATH <u>Takoma Park</u>		9c. COUNTY OF DEATH <u>MONTGOMERY</u>	
10a. STATE <u>Maryland</u>		10b. COUNTY <u>Prince Georges</u>		10c. CITY, TOWN OR LOCATION <u>Beltsville</u>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <u>11316 Evans Trail</u>		10f. ZIP CODE <u>20705</u>	
10g. CITIZEN OF WHAT COUNTRY? <u>USA</u>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <u>Korean</u>	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>Black</u>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12th</u> College (1-4 or 5+) <u></u>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Postal Clerk</u>		16b. KIND OF BUSINESS/INDUSTRY <u>US Postal Service</u>		17. FATHER'S NAME (First, Middle, Last) <u>Phillip Gibson</u>	
18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Louise I. Thomas</u>		19a. INFORMANT'S NAME (Type/Print) <u>Charles H. Thomas (Brother)</u>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>11915 Ellington Dr., Beltsville, MD 20705</u>	
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Maryland Nat'l Mem. Park</u>		20c. LOCATION — City or Town, State <u>Laurel, MD</u>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>George R. Snowden</u>		22. NAME AND ADDRESS OF FACILITY <u>SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Cardio-pulmonary Arrest</u>  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. <u>HEPATIC COMA</u> b. <u>Cirrhosis of Liver</u> c. <u>Cirrhosis of Liver</u> d. <u></u>				Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Renal Failure</u>				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <u></u>		28b. TIME OF INJURY M <u></u>	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED <u></u>		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) <u></u>	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <u>George R. Snowden</u>		29c. LICENSE NUMBER <u>D-14364</u>		29d. DATE SIGNED (Month, Day, Year) <u>2/15/91</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>M. CHANDLER HAY MD, 7610 Carroll Ave #300, Takoma Park, Md.</u>					
31. DATE FILED (Month, Day, Year) <u>FEB 19 91</u>		32. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05704

1. DECEDENT'S NAME (First, Middle, Last) Harold Lloyd Thomas				2. DATE OF DEATH MONTH 2--16-91 YEAR 91		3. TIME OF DEATH 0025 AM	
4. SOCIAL SECURITY NUMBER 182-12-2309		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 68 YRS.		7. DATE OF BIRTH (Month, Day, Year) 6 28 22 Pa.	
9a. FACILITY NAME (If not institution, give street and number) Anne Arundel Medical Center				9b. CITY, TOWN OR LOCATION OF DEATH Annapolis		9c. COUNTY OF DEATH Anne Arundel	
RESIDENCE OF DECEDENT							
10a. STATE Md		10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Galesville		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 4887 Anchors Way				10f. ZIP CODE 20765		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 01		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Engineer		16b. KIND OF BUSINESS/INDUSTRY C&P Telephone			
17. FATHER'S NAME (First, Middle, Last) Leo Jesse Thomas				18. MOTHER'S NAME (First, Middle, Maiden Surname) Hazel Logsdon			
19a. INFORMANT'S NAME (Type/Print) Jane M. Thomas				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4887 Anchors Way Galesville 20765			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory		20c. LOCATION — City or Town, State Baltimore Md			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Patricia J. ...</i>				22. NAME AND ADDRESS OF FACILITY Hardesty Funeral Home P.A. Galesville Md 20765			
23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) →  Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
a. DUE TO (OR AS A CONSEQUENCE OF): Acute Respiratory Failure							
b. DUE TO (OR AS A CONSEQUENCE OF): Metastasis to lung.							
c. DUE TO (OR AS A CONSEQUENCE OF): Renal cell Carcinoma.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER DD 8317		29d. DATE SIGNED (Month, Day, Year) 2/18/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) George C. ... 205 ...							
31. DATE FILED FEB 19 1991		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05705

1. DECEDENT'S NAME (First, Middle, Last) <b>GEORGE PNESTON TALHELM</b>				2. DATE OF DEATH MONTH <b>02</b> DAY <b>21</b> YEAR <b>91</b>		3. TIME OF DEATH <b>7:55 P. M.</b>				
4. SOCIAL SECURITY NUMBER <b>220-30-9982</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>66</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Feb. 22, 1924</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>		
9a. FACILITY NAME (If not institution, give street and number) <b>9369 Myersville Road</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Myersville</b>			9c. COUNTY OF DEATH <b>Frederick</b>			
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Frederick</b>		10c. CITY, TOWN OR LOCATION <b>Myersville</b>			10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER <b>9369 Myersville Road</b>				10f. ZIP CODE <b>21773</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 6+) <input type="checkbox"/>		18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Farm Hand</b>			18b. KIND OF BUSINESS/INDUSTRY <b>Dairy Farm</b>					
17. FATHER'S NAME (First, Middle, Last) <b>William Talhelm</b>				16. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Harp</b>						
19a. INFORMANT'S NAME (Type/Print) <b>Calvin Waters</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>24 Main Street, Myersville, Maryland 21773</b>						
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Grossnickle Ch of Brethren Cemt</b>			20c. LOCATION — City or Town, State <b>Myersville, Maryland</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>R. L. Ricketts</b>				22. NAME AND ADDRESS OF FACILITY <b>504 Main Street Ricketts Funeral Home Myersville, MD 21773</b>						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>A. S. C. U. D.</b>  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  <b>DIABETES</b> <b>HYPERTENSION</b>							Approximate Interval Between Onset and Death <b>10 yrs.</b>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DIABETES</b> <b>HYPERTENSION</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>JULIO MENZAL</b>				29c. LICENSE NUMBER <b>D31912</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/24/91</b>		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>516 TRAIL AVE - FREDERICK, MD 21701</b>										
31. DATE FILED (Month, Day, Year) <b>FEB 23 '91</b>		32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>								





91 05706

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>IDA E THOMPSON</b>		2. DATE OF DEATH MONTH <b>2</b> DAY <b>13</b> YEAR <b>91</b>		3. TIME OF DEATH <b>8:00 A M</b>	
4. SOCIAL SECURITY NUMBER <b>216-16-7612</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>75</b> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <b>Aug 26, 1915</b>		8. BIRTHPLACE (State or Foreign Country) <b>Md.</b>		9. COUNTY OF DEATH <b>Dorchester</b>	
10a. STATE <b>Md.</b>		10b. COUNTY <b>Dorchester</b>		10c. CITY, TOWN OR LOCATION <b>Cambridge</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>2059 Church Creek Rd.</b>		10f. ZIP CODE <b>21613</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY		17. FATHER'S NAME (First, Middle, Last) <b>Paul B. Sampson</b>	
18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Hattie Barnoughs</b>		19a. INFORMANT'S NAME (Type/Print) <b>Gloria Jean Thompson</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2059 Church Creek Rd. Camb. Md. 21613</b>	
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>East New Market Cemetery</b>		20c. LOCATION — City or Town, State <b>East New Market, Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Danelle C. Hey Buck</b>		22. NAME AND ADDRESS OF FACILITY <b>Henry F. H. Cambridge, Md. 21613</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Sepsis</b> a. DUE TO (OR AS A CONSEQUENCE OF): <b>Multiple myeloma</b> b. DUE TO (OR AS A CONSEQUENCE OF): <b>Leukopenia secondary to chemotherapy</b> c. DUE TO (OR AS A CONSEQUENCE OF): <b>Leukopenia 2 to chemo 14</b> d. DUE TO (OR AS A CONSEQUENCE OF): <b>CVA CVA</b> Approximate Interval Between Onset and Death <b>7 days</b> <b>11 mo</b> <b>7 days</b>					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>GI bleeding</b> <b>GI bleeding</b>					24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Hubert Fiery, M.D.</b>		29c. LICENSE NUMBER <b>D22773</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/13/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>HUBERT L. FIERY MD 503 BYRN ST, CAMBRIDGE Md</b>					
31. DATE FILED (Month, Day, Year) <b>FEB 19 91</b>		32. REGISTRAR'S SIGNATURE <b>J. A. Harrison-Randell</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

DMMH-16 Rev 1/89



REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

**BALTIMORE, MARYLAND 21203-3146**

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit certificate and be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 05709

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>William H. Weeks</b>				2. DATE OF DEATH MONTH DAY YEAR <b>2-14-91</b>		3. TIME OF DEATH M <b>0607</b>	
4. SOCIAL SECURITY NUMBER <b>230-01-2801</b>		5. SEX <b>1</b> M <b>2</b> F		6. AGE (In yrs. last birthday) <b>65</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>11-19-25</b>	
8. BIRTHPLACE (State or Foreign Country) <b>VIRGINIA</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Holy Cross ER</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>S.S. Md. 20910</b>	
9c. COUNTY OF DEATH <b>Mont.</b>				10a. STATE <b>MD</b>		10b. COUNTY <b>mont.</b>	
10c. CITY, TOWN OR LOCATION <b>S.S. 20910</b>				10d. INSIDE CITY LIMITS? <b>1</b> YES <b>2</b> NO		10e. STREET AND NUMBER <b>9023 Fairview Rd.</b>	
10f. ZIP CODE <b>20910</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <b>1</b> Never Married <b>2</b> Married <b>3</b> Widowed <b>4</b> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> YES <b>2</b> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> YES <b>2</b> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+)			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>ENGINEER, CORPORATE DIR.</b>				16b. KIND OF BUSINESS/INDUSTRY <b>HOTEL/MOTEL</b>			
17. FATHER'S NAME (First, Middle, Last) <b>JOHN G. WEEKS</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MARY HAWKS</b>			
19a. INFORMANT'S NAME (Type/Print) <b>JEAN G. WEEKS (WIFE)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9023 FAIRVIEW ROAD, SILVER SPRING, MARYLAND 20910</b>			
20a. METHOD OF DISPOSITION <b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>BLANDFORD CEMETERY</b>			
20c. LOCATION — City or Town, State <b>PETERSBURG, VIRGINIA</b>				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Michael J. Bigler</b>			
22. NAME AND ADDRESS OF FACILITY <b>FRANCIS J. COLLINS FUNERAL HOME, INC.</b> <b>500 UNIVERSITY BLVD., W., SIL.SP., MD 20901</b>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ACUTE MYOCARDIAL INFARCTION</b> DUE TO (OR AS A CONSEQUENCE OF): <b>CORONARY ARTERY DISEASE</b> DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death <b>3 WEEKS</b> <b>1 YEAR</b>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ESSENTIAL HYPERTENSION</b>				24a. WAS AN AUTOPSY PERFORMED? <b>1</b> YES <b>2</b> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1</b> YES <b>2</b> NO				25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> YES <b>2</b> NO			
26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA OTHER: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify)				27. MANNER OF DEATH <b>1</b> Natural <b>2</b> Accident <b>3</b> Suicide <b>4</b> Homicide <b>5</b> Pending Investigation <b>6</b> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY <b>M</b>			
28c. INJURY AT WORK? <b>1</b> YES <b>2</b> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <b>1</b> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <b>Edward A. Beeman MD</b>			
29c. LICENSE NUMBER <b>DO 3604</b>				29d. DATE SIGNED (Month, Day, Year) <b>FEB 14, 1991</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>EDWARD A. BEEMAN, M.D., 8830 CAMERON ST. SILVER SPRING, MD 20910</b>				31. DATE FILED (Month, Day, Year) <b>FEB 19 '91</b>			
32. REGISTRAR'S SIGNATURE <b>Johanna Davidson-Russell</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

315

ENCLOSURE

1-1-1950

1-1-1950



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, and 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				CERTIFICATE OF DEATH				REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last) SYRELIUS WILLS SR.						2. DATE OF DEATH MONTH DAY YEAR FEB. 17, 1991				3. TIME OF DEATH 0933 A M					
4. SOCIAL SECURITY NUMBER 218-12-9686		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 71 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 30, 1919		8. BIRTHPLACE (State or Foreign Country) Maryland							
9a. FACILITY NAME (If not institution, give street and number) CALVERT MEMORIAL HOSPITAL						9b. CITY, TOWN OR LOCATION OF DEATH PRINCE FREDERICK, MD				9c. COUNTY OF DEATH CALVERT					
10a. STATE Maryland		10b. COUNTY Calvert		10c. CITY, TOWN OR LOCATION Owings				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 1933 Horace Ward Road				10f. ZIP CODE 20736				10g. CITIZEN OF WHAT COUNTRY? USA							
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: Black							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 0-5 College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Custodian				16b. KIND OF BUSINESS/INDUSTRY							
17. FATHER'S NAME (First, Middle, Last) James A. Wills						18. MOTHER'S NAME (First, Middle, Maiden Surname) Priscilla Brown									
19a. INFORMANT'S NAME (Type/Print) Ida E. Wills				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1933 Horace Ward Rd. Owings, Maryland 20736											
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Wards Memorial Chr. Cemetery				20c. LOCATION — City or Town, State Owings, Maryland							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Spencer E. Sewell				22. NAME AND ADDRESS OF FACILITY 1451 Dares Beach Rd. Sewell Funeral Home Prince Frederick, Md											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CORONARY ARTERY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.										Approximate Interval Between Onset and Death YEARS					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER Charles Judge, M.D.				29c. LICENSE NUMBER 029657		29d. DATE SIGNED (Month, Day, Year) 2/17/91					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) CHARLES JUDGE, M.D. PRINCE FREDERICK, MARYLAND 20678															
31. DATE FILED (Month, Day, Year) FEB 21 1991				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall											

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1-4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				CERTIFICATE OF DEATH		REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last)		Thomas S. Wilson				2. DATE OF DEATH MONTH DAY YEAR		3. TIME OF DEATH	
Thomas S. Wilson						2 18 91		2:18 P.M.	
4. SOCIAL SECURITY NUMBER		5. SEX		6. AGE (In yrs. last birthday)		7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHPLACE (State or Foreign Country)	
579-22-2953		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		76 YRS.		Dec. 25, 1914		New York	
9a. FACILITY NAME (If not institution, give street and number)				9b. CITY, TOWN OR LOCATION OF DEATH				9c. COUNTY OF DEATH	
Herman Wilson Health Care Center				Gaithersburg				Montgomery	
10a. STATE		10b. COUNTY		10c. CITY, TOWN OR LOCATION				10d. INSIDE CITY LIMITS?	
---		---		Washington, D.C.				1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER				10f. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?			
7071 Western Avenue, N.W.				20015		U.S.A.			
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES?		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)		14. RACE — American Indian, Black, White, etc. Specify:			
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY			
Elementary/Secondary (9-12) College (1-4 or 5+)				Chief Accountant		U.S. Gov't.			
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)					
Fred Wilson				Ada Farnsworth					
19a. INFORMANT'S NAME (Type/Print)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)					
Ethel M. Wilson				7071 Western Ave., NW, Washington, D.C. 20015					
20a. METHOD OF DISPOSITION		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)		20c. LOCATION — City or Town, State					
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		Metropolitan Crematory		Alexandria, VA					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE				22. NAME AND ADDRESS OF FACILITY					
Michael S. Nelson				Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave, NW, Washington, D.C. 20016					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Aspiration Pneumonia								1 month.	
Due to (or as a consequence of): b. Cerebral hemorrhage								3 month	
Due to (or as a consequence of): c.									
Due to (or as a consequence of): d.									
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one)							
		HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK?		28d. DESCRIBE HOW INJURY OCCURRED	
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				M		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29. CERTIFIER (Check only one)		29c. LICENSE NUMBER							
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		07231							
29b. SIGNATURE AND TITLE OF CERTIFIER		29d. DATE SIGNED (Month, Day, Year)							
James R. Moore Jr.		2-18-91							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)									
James R. Moore Jr. 207 Brookes Ave Gaithersburg Md.									
31. DATE FILED (Month, Day, Year)		32. REGISTRAR'S SIGNATURE							
FEB 20 '91		Julia Davidson-Randall							







DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last) Ruth Marion Link WIGLEY						2. DATE OF DEATH FEB. 15, 1991		3. TIME OF DEATH 2:30A					
4. SOCIAL SECURITY NUMBER 204-18-4953		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 63 YRS.	7. DATE OF BIRTH (Month, Day, Year) APR. 12, 1927		8. BIRTHPLACE (State or Foreign Country) PA.							
9a. FACILITY NAME (If not institution, give street and number) DOCTORS COMMUNITY HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH LANHAM			9c. COUNTY OF DEATH PRINCE GEORGE'S						
10a. STATE MD.		10b. COUNTY PRINCE GEORGES		10c. CITY, TOWN OR LOCATION GREENBELT			10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO						
10e. STREET AND NUMBER 29 WOODLAND WAY				10f. ZIP CODE 20770		10g. CITIZEN OF WHAT COUNTRY? U.S.A.							
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) REGISTERED NURSE-RET.			16b. KIND OF BUSINESS/INDUSTRY NURSING							
17. FATHER'S NAME (First, Middle, Last) CHARLES A. LINK SR.					18. MOTHER'S NAME (First, Middle, Maiden Surname) DOROTHY V. BROOM								
19a. INFORMANT'S NAME (Type/Print) DAVID WIGLEY				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 314 SPINDRIFT WAY, VACAVILLE, CAL. 95687									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) FT. LINCOLN CEMETERY 2/18/91		20c. LOCATION — City or Town, State BRENTWOOD, MD.									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE W.W. Chambers MO0091				22. NAME AND ADDRESS OF FACILITY W. W. CHAMBERS CO. INC., RIVERDALE, MD. 20737									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>massive intracerebral hemorrhage</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>coma</u> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST										Approximate interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Possible Bronchogenic Carcinoma</u>										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined			28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED				
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. SIGNATURE AND TITLE OF CERTIFIER John Davidson			29c. LICENSE NUMBER D13239		29d. DATE SIGNED (Month, Day, Year) 2/15/91					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) T. L. Davidson, 8824 CUMMINGS DR, BERWYN HEIGHTS, MD.													
31. DATE FILED (Month, Day, Year) FEB 19 '91			32. REGISTRAR'S SIGNATURE John Davidson										





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 7, 8 and 9 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				CERTIFICATE OF DEATH				REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last) Roger Taylor Warren, Sr.						2. DATE OF DEATH MONTH 02 DAY 19 YEAR 91				3. TIME OF DEATH 3:55 A.M.					
4. SOCIAL SECURITY NUMBER 212-03-6317		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 89 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) 01/07/02		8. BIRTHPLACE (State or Foreign Country) MD			
9a. FACILITY NAME (If not institution, give street and number) 700 Mill Creek Road						9b. CITY, TOWN OR LOCATION OF DEATH Arnold				9c. COUNTY OF DEATH Anne Arundel					
10a. STATE MD						10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Arnold				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 700 Mill Creek Road						10f. ZIP CODE 21012				10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) +		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Vice-President/Gen. Mgr.				15b. KIND OF BUSINESS/INDUSTRY Marina									
17. FATHER'S NAME (First, Middle, Last) Frederick Warren						18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary J. Myers									
19a. INFORMANT'S NAME (Type/Print) Mrs. Dorothy K. Warren				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 700 Mill Creek Road Arnold MD 21012											
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory				20c. LOCATION — City or Town, State Catonsville, MD							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert A. S.B.				22. NAME AND ADDRESS OF FACILITY 495 Ritchie Hwy. Barranco Funeral Home Severna Park MD 21146											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Chronic Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF): b. Coronary Artery Heart Disease DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST										Approximate Interval Between Onset and Death					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER Dr. Robert A. Alexander, MD						29c. LICENSE NUMBER				29d. DATE SIGNED (Month, Day, Year) 2-20-91					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Robert A. Alexander, MD 1300 Ritchie Hwy 21012															
31. DATE FILED (Month, Day, Year) FEB 22 1991				32. REGISTRAR'S SIGNATURE John Davidson-Randall											



91 05715

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Ralph Merrill Wismer</b>				2. DATE OF DEATH MONTH DAY YEAR <b>02 16 91</b>		3. TIME OF DEATH <b>12:30 PM</b>	
4. SOCIAL SECURITY NUMBER <b>328-10-3235</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		8. AGE (in yrs. last birthday) <b>80</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>1-24-11</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Kennelwood Manor</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Millersville, MD</b>		9c. COUNTY OF DEATH <b>Anne Arundel</b>			
10a. STATE <b>MD</b>				10b. COUNTY <b>Anne Arundel</b>		10c. CITY, TOWN OR LOCATION <b>Severna Park</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER <b>614 Banyon Ave.</b>				10f. ZIP CODE <b>21146</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>1940-1966</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (14 or 5+) <b>+</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Retired Colonel</b>		16b. KIND OF BUSINESS/INDUSTRY <b>U.S. M.C.</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Ralph J. Wismer</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Louise Garrow</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mrs. Jean Wismer</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Game 15 # 10</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Arlington NATL cem.</b>		20c. LOCATION — City or Town, State <b>Arlington, VA</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Robert S. Bonham</b>				22. NAME AND ADDRESS OF FACILITY <b>SEVERNA PARK, MD 21146</b> <b>BARRANCO AND SONS FUNERAL HOME</b>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Congestive Heart failure</b> Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <b>arteriosclerotic Cardiovascular disease</b> b. <b>Due to (or as a consequence of):</b> c. <b>Due to (or as a consequence of):</b> d. <b>Due to (or as a consequence of):</b>						Approximate Interval Between Onset and Death <b>4 years</b> <b>4 years</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Marked debilitated</b>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						28. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>TG Callis MD</b>				29c. LICENSE NUMBER <b>001879</b>		29d. DATE SIGNED (Month, Day, Year) <b>Feb 16, 1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>TG Callis MD 7 Riggs Ave Severna Park Md 21146</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 19 1991</b>		32. REGISTRAR'S SIGNATURE <b>Jake Davidson-Randall</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1-5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1-4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05716

1. DECEDENT'S NAME (First, Middle, Last) JOHN M WALKER						2. DATE OF DEATH MONTH DAY YEAR 2 5 91		3. TIME OF DEATH 1:30 PM		
4. SOCIAL SECURITY NUMBER 061-09-2149		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 84 YRS.		7. DATE OF BIRTH (Month, Day, Year) 3-9-06		8. BIRTHPLACE (State or Foreign Country) Baltimore, MD		
9a. FACILITY NAME (If not institution, give street and number) Meridian - The Pines						9b. CITY, TOWN OR LOCATION OF DEATH Easton, Maryland			9c. COUNTY OF DEATH Talbot	
10a. STATE MD		10b. COUNTY Talbot		10c. CITY, TOWN OR LOCATION Claiborne				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		
10e. STREET AND NUMBER #1 Harrison Street				10f. ZIP CODE 21624		10g. CITIZEN OF WHAT COUNTRY?				
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII Army		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11		College (1-4 or 5+) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Engineer			16b. KIND OF BUSINESS/INDUSTRY Engineering			
17. FATHER'S NAME (First, Middle, Last) John Moseley Walker, Jr.						18. MOTHER'S NAME (First, Middle, Maiden Surname) Sarah Lee				
19a. INFORMANT'S NAME (Type/Print) Lee T. Walker				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) #1 Harrison Street Claiborne, MD 21624						
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Eastern Shore Crematory				20c. LOCATION — City or Town, State Georgetown, DE				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE JOHN B. MERCER				22. NAME AND ADDRESS OF FACILITY Newnam Funeral Home 200 S. Harrison St. Easton, MD						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>ASPIRATION PNEUMONIA</u> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. c. d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>PRIOR STROKE, ARTHROSCLOTIC CARDIOVASCULAR DISEASE</u>								Approximate Interval Between Onset and Death 48 hours		
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO								
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		25. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER Ludwig T. Eglseder III MD						29c. LICENSE NUMBER MD D 31466		29d. DATE SIGNED (Month, Day, Year) 2/5/91		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Ludwig T. Eglseder III MD, 606 DUTCHMAN'S LANE EASTON MD 21601										
31. DATE FILED (Month, Day, Year) FEB - 8 '91				32. REGISTRAR'S SIGNATURE John K. ...						



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05717

1. DECEDENT'S NAME (First, Middle, Last) Wendell Shreve Warner				2. DATE OF DEATH MONTH 2 DAY 10 YEAR 91		3. TIME OF DEATH 9:05 P M					
4. SOCIAL SECURITY NUMBER 213-12-0101		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 74 YRS.		7. DATE OF BIRTH (Month, Day, Year) 5 12 16		8. BIRTHPLACE (State or Foreign Country) MD			
9a. FACILITY NAME (If not institution, give street and number) 723 Wayside Avenue				9b. CITY, TOWN OR LOCATION OF DEATH Easton			9c. COUNTY OF DEATH Talbot				
10a. STATE 21601			10b. COUNTY Talbot			10c. CITY, TOWN OR LOCATION Easton			10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
10e. STREET AND NUMBER 723 Wayside Avenue				10f. ZIP CODE 21601			10g. CITIZEN OF WHAT COUNTRY? USA				
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (14 or 5+) _____				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Carpenter			16b. KIND OF BUSINESS/INDUSTRY House Building				
17. FATHER'S NAME (First, Middle, Last) Walter Roy Warner				18. MOTHER'S NAME (First, Middle, Maiden Surname) Bessie Belle Robinson							
19a. INFORMANT'S NAME (Type/Print) Elsie R. Warner				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 723 Wayside Avenue Easton, MD 21601							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) MD Veterans Cemetery			20c. LOCATION — City or Town, State Hurlock, MD						
21. SIGNATURE OF FUNERAL SERVICE LICENSEE John R. Mercer				22. NAME AND ADDRESS OF FACILITY Newnam Funeral Home 200 S. Harrison Easton, MD 21601							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Lung carcinoma Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. _____								Approximate Interval Between Onset and Death 3 months			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____ _____								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____							
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide <input type="checkbox"/> _____				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER David H. Smith MD				29c. LICENSE NUMBER D39887		29d. DATE SIGNED (Month, Day, Year) FEB 13 91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) David Smith, MD 509 Idlewild Ave. Easton, MD 21601											
31. DATE FILED (Month, Day, Year) FEB 13 91				32. REGISTRAR'S SIGNATURE John R. Mercer							





**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

**DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146**

DHH-16 Rev 1/89



91 05719

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Raymond N. Weber</b>		2. DATE OF DEATH MONTH <b>February</b> DAY <b>7</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>1115</b> M
4. SOCIAL SECURITY NUMBER <b>077-14-3894</b>	5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>80</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>3-10-1910</b>	8. BIRTHPLACE (State or Foreign Country) <b>New York</b>
9a. FACILITY NAME (If not institution, give street and number) <b>PENINSULA GENERAL HOSPITAL</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>SALISBURY</b>		9c. COUNTY OF DEATH <b>WICOMICO</b>
RESIDENCE OF DECEDENT				
10a. STATE <b>Maryland</b>	10b. COUNTY <b>Anne Arundel</b>	10c. CITY, TOWN OR LOCATION <b>Annapolis</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
10e. STREET AND NUMBER <b>217 S Cherry Grove Ave.</b>		10f. ZIP CODE <b>21401</b>	10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b></b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Radio Marine</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Electronics</b>
17. FATHER'S NAME (First, Middle, Last) <b>Henry Weber</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Ida Wolfgang</b>		
19a. INFORMANT'S NAME (Type/Print) <b>Richard N. Weber</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Rt6 Box 306 Salisbury, Md. 21801</b>		
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Hillcrest Cemetery</b>		20c. LOCATION — City or Town, State <b>Annapolis, Md.</b>
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert L. Saylor</i>		22. NAME AND ADDRESS OF FACILITY <b>Taylor Funeral Chapel Annapolis, Md.</b>		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Myocardial Infarction</b> a. DUE TO (OR AS A CONSEQUENCE OF): <b>A SCVD</b> b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. SEQUENTIALLY LIST CONDITIONS, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST				Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Depression</b> <b>Hx Colon Ca.</b>				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY <b>M</b>	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Christion Huddleston</i>		29c. LICENSE NUMBER <b>D.29105</b>	29d. DATE SIGNED (Month, Day, Year) <b>2/7/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Christion Huddleston 103 Poplar Ave Fruitland, Md.</b>				
31. DATE FILED (Month, Day, Year) <b>FEB 19 1991</b>		32. REGISTRAR'S SIGNATURE <i>Jillia Davidson-Rendell</i>		

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05720

1. DECEDENT'S NAME (First, Middle, Last) <b>Noah Wilson</b>				2. DATE OF DEATH MONTH DAY YEAR <b>01 - 02 - 91</b>				3. TIME OF DEATH <b>9:35 A M</b>	
4. SOCIAL SECURITY NUMBER <b>24-28-7950</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>84</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) <b>Dec 9, 1907</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Dorchester Gen Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Cambridge</b>				9c. COUNTY OF DEATH <b>Md.</b>	
10a. STATE <b>Md.</b>		10b. COUNTY <b>Talbot</b>		10c. CITY, TOWN OR LOCATION <b>Trappe</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>RT I Box 321</b>				10f. ZIP CODE <b>21673</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)			16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>Noah Wilson</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Martina Brown Wilson</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Vivian Roberts</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>RT I Box 321 Trappe Md. 21673</b>					
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Paradise Ceme</b>		20c. LOCATION — City or Town, State <b>Trappe Md.</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Janelle C. Henry Buck</b>				22. NAME AND ADDRESS OF FACILITY <b>Henry Howard Home Camb. Md. 21613</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiopulmonary arrest</b>  Sequitely flat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>a. <b>Cardiopulmonary arrest</b> DUE TO (OR AS A CONSEQUENCE OF):</p> <p>b. <b>Intracerebral bleed.</b> DUE TO (OR AS A CONSEQUENCE OF):</p> <p>c.  DUE TO (OR AS A CONSEQUENCE OF):</p> <p>d.  DUE TO (OR AS A CONSEQUENCE OF):</p> </div> <div style="width: 35%; text-align: center;"> <p>Approximate Interval Between Onset and Death</p> </div> </div>									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
				28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>W. Krawinkel M.D.</b>		29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>18</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)									
31. DATE FILED (Month, Day, Year) <b>FEB 19 '91</b>		32. REGISTRAR'S SIGNATURE <b>J. Davidson-Randall</b>							



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH REG. NO.

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>CHARLES O. WALTERS</b>		2. DATE OF DEATH MONTH DAY YEAR <b>February 16, 1991</b>		3. TIME OF DEATH <b>3:20 P M</b>	
4. SOCIAL SECURITY NUMBER <b>705-12-4206</b>		5. SEX <b>XX</b> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>71</b> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <b>01-14-1920</b>		8. BIRTHPLACE (State or Foreign Country) <b>WV</b>		9. FACILITY NAME (If not institution, give street and number) <b>Memorial Hospital</b>	
10a. STATE <b>MD</b>		10b. COUNTY <b>Allegany</b>		10c. CITY, TOWN OR LOCATION <b>Oldtown,</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>Route 1 Box 92</b>		10f. ZIP CODE <b>21555</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>12</b>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>ret. self-employed</b>		16b. KIND OF BUSINESS/INDUSTRY <b>contractor</b>		17. FATHER'S NAME (First, Middle, Last) <b>Charles Walters</b>	
18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Myrtle Buckley</b>		19a. INFORMANT'S NAME (Type/Print) <b>Mrs. Frances J. Walters</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Route 1 Box 92 Oldtown, MD 21555</b>	
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Rosedale Funeral Chapel</b>		20c. LOCATION — City or Town, State <b>Martinsburg, WV</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Jones J. Scarpelli</b>		22. NAME AND ADDRESS OF FACILITY <b>Scarpelli Funeral Home Cumberland, MD 21502</b>		23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Recurrent C.V.A</b> <b>2. Atherosclerotic Fibrosis vs Pul Embolisms</b> <b>Metastatic Ca. Prostate -</b>	
23. PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. <b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b>		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>Dr Omar Zaman</b>		29c. LICENSE NUMBER <b>D 23371</b>	
29d. DATE SIGNED (Month, Day, Year) <b>2/16/91</b>		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr Omar Zaman Memorial Hospital Medical Building Cumberland, Md. 21502</b>		31. DATE FILED (Month, Day, Year) <b>FEB 19 1991</b>	
32. REGISTRAR'S SIGNATURE <b>G. Davidson-Randall</b>					

**BALTIMORE, MARYLAND 21203-3146**

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

**IMPORTANT:** If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

**IMPORTANT:** If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

**TO BE COMPLETED BY FUNERAL DIRECTOR**





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 7 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05722

1. DECEDENT'S NAME (First, Middle, Last) <b>ROSA</b>				2. DATE OF DEATH MONTH <b>February</b> DAY <b>2</b> YEAR <b>1991</b>				3. TIME OF DEATH <b>8:50 PM</b>		
4. SOCIAL SECURITY NUMBER <b>213-22-4478</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>81</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>11/15/09</b>		8. BIRTHPLACE (State or Foreign Country) <b>West Virginia</b>		
9a. FACILITY NAME (If not institution, give street and number) <b>Memorial Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Cumberland</b>				9c. COUNTY OF DEATH <b>Allegany</b>		
10a. STATE <b>Maryland</b>			10b. COUNTY <b>Allegany</b>			10c. CITY, TOWN OR LOCATION <b>Westernport</b>			10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>201 Clayton Ave</b>				10f. ZIP CODE <b>21562</b>				10g. CITIZEN OF WHAT COUNTRY? <b>usa</b>		
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>n/a</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>House</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Domestic</b>		
17. FATHER'S NAME (First, Middle, Last) <b>Samuel Funkhouser</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Victoria Wilkins</b>						
19a. INFORMANT'S NAME (Type/Print) <b>James Mills</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>25 E Main St. Lonaconing Md. 21539</b>						
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Rest Lawn Memorial Gardens</b>				20c. LOCATION — City or Town, State <b>Cumberland Md.</b>		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Wayne Boal</i>				22. NAME AND ADDRESS OF FACILITY <b>Boal-Warnick Funeral Home Westernport, Md. 21562</b>						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardio-Respiratory Arrest</b>  Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <b>Renal Failure</b>  <b>Tight Aortic Stenosis</b>  <b>Diabetes Mellitus</b> </div> <div style="width: 45%; text-align: right;">           Approximate Interval Between Onset and Death         </div> </div>										
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
				28d. DESCRIBE HOW INJURY OCCURED						
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Jam</i> MD				29c. LICENSE NUMBER <b>D23371</b>				29d. DATE SIGNED (Month, Day, Year) <b>2/3/91</b>		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Zaman Memorial Hospital Medical Building Cumberland, MD. 21502</b>										
31. DATE FILED (Month, Day, Year) <b>FEB 19 1991</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>						



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05723

1. DECEDENT'S NAME (First, Middle, Last) <b>CHAYA YUDELEVITZ</b>		2. DATE OF DEATH MONTH <b>2</b> DAY <b>13</b> YEAR <b>91</b>		3. TIME OF DEATH <b>7:45</b> M	
4. SOCIAL SECURITY NUMBER <b>080-24-1376</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>92</b> YRS.	
7a. FACILITY NAME (If not institution, give street and number) <b>Hebrew Home of Greater Washington</b>		7b. CITY, TOWN OR LOCATION OF DEATH <b>Rockville</b>		7c. COUNTY OF DEATH <b>MONTGOMERY</b>	
10a. STATE <b>MD</b>		10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Rockville</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>6121 Montrose Road</b>		10f. ZIP CODE <b>20852</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Self Employed</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Dressmaker</b>		17. FATHER'S NAME (First, Middle, Last) <b>Zelman Cantor</b>	
18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Chana (Unknown)</b>		19a. INFORMANT'S NAME (Type/Print) <b>Harry Levitt, Son</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3309 Shirley Lane, Chevy Chase, MD 20815</b>	
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Wellwood Cemetery</b>		20c. LOCATION — City or Town, State <b>Farmingdale, N.Y.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY <b>Danzansky-Goldberg Memorial Chapels 1170 Rockville Pike, Rockville, MD 20852</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ACUTE CEREBRAL THROMBOSIS</b> DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):		Approximate Interval Between Onset and Death <b>2 DAYS</b>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>MULTI-INFARCT DEMENTIA</b>		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>Dr. D. Patel, M.D. ATTENDING PHYSICIAN</b>		29c. LICENSE NUMBER <b>D-18084</b>	
29d. DATE SIGNED (Month, Day, Year) <b>2/14/91</b>		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>D.D. PATEL, M.D. 6121 MONTROSE RD, ROCKVILLE, MD. 20852</b>			
31. DATE FILED (Month, Day, Year) <b>FEB 14 '91</b>		32. REGISTRAR'S SIGNATURE 			



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05724

1. DECEDENT'S NAME (First, Middle, Last) <b>MARY HELEN YOUNG</b>				2. DATE OF DEATH MONTH <b>FEB</b> DAY <b>11</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>1:42 PM</b>			
4. SOCIAL SECURITY NUMBER <b>235-01-6994</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (in yrs. last birthday) <b>73</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>March 30, 1917</b>		8. BIRTHPLACE (State or Foreign Country) <b>West Virginia</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>SHADY GROVE ADVENTIST HOSP</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Rockville</b>				9c. COUNTY OF DEATH <b>Montgomery</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Germantown</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>20004 Sweetgum Circle Apt. #14</b>				10f. ZIP CODE <b>20874</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Resident Manager</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Apartment Manager</b>					
17. FATHER'S NAME (First, Middle, Last) <b>Homer Sheets</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mabel Deck</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Robert M. Young</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>18520 Eagles Roost Dr. Germantown, MD 20874</b>					
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metropolitan Crematory</b>		20c. LOCATION — City or Town, State <b>Alexandria, Virginia</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>J.C. Bell</b>		22. NAME AND ADDRESS OF FACILITY <b>DeVol Funeral Home</b> <b>10 E. Deer Park Dr.—Gaithersburg, MD 20877</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>ACUTE CARDIOPULMONARY AND RENAL FAILURE</b> <b>DUE TO (OR AS A CONSEQUENCE OF):</b> <b>OPPORTUNISTIC PULMONARY INFECTION</b> <b>DUE TO (OR AS A CONSEQUENCE OF):</b> <b>MALIGNANT LYMPHOMA, NODULAR MIXED TYPE</b> <b>DUE TO (OR AS A CONSEQUENCE OF):</b> <b>Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> <b>18 YRS</b>				Approximate Interval Between Onset and Death <b>1 WK</b>					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HYPERTENSION</b>				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <b>James A. Brown MD</b>				29c. LICENSE NUMBER <b>D07285</b>		29d. DATE SIGNED (Month, Day, Year) <b>Feb. 11, 1991</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>JAMES A. BROWN MD 14808 PHYSICIANS LANE #212 ROCKVILLE MD</b>									
31. DATE FILED (Month, Day, Year) <b>FEB 14 '91</b>			32. REGISTRAR'S SIGNATURE <b>Julie Davidson-Randall</b>						



91 05725

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Cornelius Charles Yorker</b>				2. DATE OF DEATH MONTH <b>2</b> DAY <b>12</b> YEAR <b>91</b>		3. TIME OF DEATH <b>11:35P M</b>	
4. SOCIAL SECURITY NUMBER <b>218-20-4498</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>78</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>8-14-12</b>	
8. BIRTHPLACE (State or Foreign Country) <b>md.</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Memorial Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Easton</b>	
9c. COUNTY OF DEATH <b>Talbot</b>				10a. STATE <b>md.</b>		10b. COUNTY <b>QA</b>	
10c. CITY, TOWN OR LOCATION <b>Seenstein</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>bloomingdale Rd.</b>	
10f. ZIP CODE <b>21658</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Blk</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input checked="" type="checkbox"/> College (14 or 5+) <input type="checkbox"/>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>laborer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Farm work</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Herbert Yorker</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Nettie Harris</b>			
19a. INFORMANT'S NAME (Type/Print) <b>James Ford</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Rt 2 Box 360 Seenstein, md. 21658</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Carmichael</b>		20c. LOCATION — City or Town, State <b>218/91 Carmichael, md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>George H. Dashiell Funeral services 315 Dover St. Easton</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Carcinoma of the Colon</b> DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death <b>WKS</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ABCD Alcoholism</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D05874</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/13/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR. Lewis 506 Idlewild Ave. Easton, md. 21651</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 14 '91</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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91 05726

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>FANNIE ZUCK</b>				2. DATE OF DEATH MONTH <b>2</b> DAY <b>17</b> YEAR <b>91</b>		3. TIME OF DEATH <b>7:15 A<sup>M</sup></b>	
4. SOCIAL SECURITY NUMBER <b>213-48-7557</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>83</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>5/7/07</b>	
8. BIRTHPLACE (State or Foreign Country) <b>POLAND</b>				9. COUNTY OF DEATH <b>MONTGOMERY</b>			
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Rockville</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>6121 Montrose Road</b>			
10f. ZIP CODE <b>20852</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>Housewife</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Abraham Wishner</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Anna (Unknown)</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Joshua Zuck (son)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11746 Lovejoy Street; Silver Spring, Md. 20902</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Osonation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Elesavetgrad; Beth Shalom Congregation Cemetery; Washington, D.C.</b>		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Frank A. Stone</i>				22. NAME AND ADDRESS OF FACILITY <b>Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike; Rockville, Md. 20852</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>PNEUMONIA</b> a. DUE TO (OR AS A CONSEQUENCE OF): b. <b>STROKE</b> c. DUE TO (OR AS A CONSEQUENCE OF): d. <b>MULTI-INFARCT DEMENTIA</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>MULTI-INFARCT DEMENTIA</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Barbara Carroll, MD</i>				29c. LICENSE NUMBER <b>D38392</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/17/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>BARBARA CARROLL, 6105 MONTROSE RD, ROCKVILLE</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 20 '91</b>		32. REGISTRAR'S SIGNATURE <i>Gulie Davidson-Randell</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 05727

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Elizabeth Anderson				2. DATE OF DEATH MONTH DAY YEAR March 1, 1991		3. TIME OF DEATH 5:30pm M	
4. SOCIAL SECURITY NUMBER		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 70 YRS.		7. DATE OF BIRTH (Month, Day, Year) March 11, 1920		8. BIRTHPLACE (State or Foreign Country) West Virginia
9a. FACILITY NAME (If not institution, give street and number) 7216 Oliver Beach Road				9b. CITY, TOWN OR LOCATION OF DEATH Middle River		9c. COUNTY OF DEATH Baltimore	
RESIDENCE OF DECEDENT							
10a. STATE Md.		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Middle River		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 7216 Oliver Beach Road				10f. ZIP CODE 21220		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Clerk		16b. KIND OF BUSINESS/INDUSTRY A & P	
17. FATHER'S NAME (First, Middle, Last) Reed Walney				18. MOTHER'S NAME (First, Middle, Maiden Surname)			
19a. INFORMANT'S NAME (Type/Print) Patricia Martinez				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1121 Sandystone Road Baltimore Md. 21221			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Holly Hill Cemetery		DATE		20c. LOCATION — City or Town, State Baltimore MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Connelly Funeral Home				22. NAME AND ADDRESS OF FACILITY Connelly Funeral Home 300 Mace Ave. 21221			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Metastatic Small Cell</u>							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
23. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER M.D. MYOTHAU				29c. LICENSE NUMBER D18487		29d. DATE SIGNED (Month, Day, Year) 3/4/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 9101 FRANKLIN SO. DR, BALTO, MD 21237							
31. DATE FILED (Month, Day, Year) MAR 05 1991				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05728

1. DECEDENT'S NAME (First, Middle, Last) MARY DILLON AGER - GUNN				2. DATE OF DEATH MONT. 3-1-91 DAY YEAR		3. TIME OF DEATH 8:45 A. M					
4. SOCIAL SECURITY NUMBER 220-44-7541		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) 92 YRS.		7. DATE OF BIRTH (Month, Day, Year) 8-1-98		9. BIRTHPLACE (State or Foreign Country) PENNSYLVANIA			
9a. FACILITY NAME (If not institution, give street and number) MERIDIAN-HOMEWOOD NURSING HOME				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE			9c. COUNTY OF DEATH				
10a. STATE MARYLAND			10b. COUNTY		10c. CITY, TOWN OR LOCATION BALTIMORE CITY			10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER 6000 BELLONA AVE.				10f. ZIP CODE 21212		10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: WHITE				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4+			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE			16b. KIND OF BUSINESS/INDUSTRY OWN HOME					
17. FATHER'S NAME (First, Middle, Last) JOSEPH DILLON				18. MOTHER'S NAME (First, Middle, Maiden Surname) MARY O'MALLEY							
19a. INFORMANT'S NAME (Type/Print) MARGUERITE G. WOODSIDE				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12811 BADCOCK LANE, BOWIE, MARYLAND 20715							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) PARKWOOD CEMETERY		20c. LOCATION — City or Town, State BALTIMORE, MD. 21234							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE R. G. Butt				22. NAME AND ADDRESS OF FACILITY HENRY W. JENKINS & SONS 4905 YORK RD. BALTO. MD. 21212							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cerebrovascular Accident DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. Cerebral Arteriosclerosis DUE TO (OR AS A CONSEQUENCE OF): c. Senescent Arteriosclerosis DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death instant years years			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Senile Dementia								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER Walter R. Welzant M.D.						29c. LICENSE NUMBER D 12039		29d. DATE SIGNED (Month, Day, Year) MARCH 1, 1991			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) WALTER R. WELZANT M.D. 6100 YORK ROAD, BALTIMORE, MD. 21212											
31. DATE FILED (Month, Day, Year) MAR 5 1991				32. REGISTRAR'S SIGNATURE Julia Davidson-Rendall							



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be attached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05729

1. DECEDENT'S NAME (First, Middle, Last) <b>JAMES REESE BRANCH</b>			2. DATE OF DEATH MONTH <b>2</b> DAY <b>21</b> YEAR <b>91</b>		3. TIME OF DEATH <b>1655</b> M
4. SOCIAL SECURITY NUMBER <b>214 50 7906</b>	5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>56</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>7/11/34</b>	8. BIRTHPLACE (State or Foreign Country) <b>Virginia</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>1437 Middletown</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Annapolis</b>		9c. COUNTY OF DEATH <b>AA</b>	
10a. STATE <b>MD</b>		10b. COUNTY <b>Anne Arundel Co</b>		10c. CITY, TOWN OR LOCATION <b>Annapolis</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>1437 Middletown</b>		10f. ZIP CODE <b>21401</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>Army Yes</b>	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify:		15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>College (1-4 or 5+)</b>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY <b>Construction Worker</b>		17. FATHER'S NAME (First, Middle, Last) <b>BUBBER BRANCH</b>	
18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>CARRIE LOU MASON</b>		19a. INFORMANT'S NAME (Type/Print) <b>Mrs Queen Branch Wife</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5 Hull Street, Brooklyn NY 11233</b>	
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Ronald Wade, Dir 3/4/91</b>		22. NAME AND ADDRESS OF FACILITY <b>State Anatomy Board 655 W. Baltimore St, Balto, MD 21201</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiac Failure</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Cardiomyopathy</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>CHF, ETOH Abuse</b>					Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <b>William P. Jones, MD Deputy</b>		29c. LICENSE NUMBER <b>D06054</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/22/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>William P. Jones, MD 695 America 21035</b>					
31. DATE FILED (Month, Day, Year) <b>MAR 5 1991</b>		32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				91 05730							
CERTIFICATE OF DEATH				REG. NO.											
1. DECEDENT'S NAME (First, Middle, Last) Lorenz Henry Bach				2. DATE OF DEATH MONTH 3/04/91 YEAR 12:34 A M				3. TIME OF DEATH							
4. SOCIAL SECURITY NUMBER 220-07-8724		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		8. AGE (In yrs. last birthday) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) 7/12/08		8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not institution, give street and number) Chapel Hill Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Randallstown				9c. COUNTY OF DEATH Baltimore Co							
10a. STATE Maryland				10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Randallstown				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER 40 Sheraton Road				10f. ZIP CODE 21133				10g. CITIZEN OF WHAT COUNTRY? U.S.A.							
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: Caucasian							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Inspector Westinghouse House				16b. KIND OF BUSINESS/INDUSTRY							
17. FATHER'S NAME (First, Middle, Last) William Bach				18. MOTHER'S NAME (First, Middle, Maiden Surname) Catherine Vermillion											
19a. INFORMANT'S NAME (Type/Print) Mrs. Ida K. Cassell Bach				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 40 Sheraton Road Randallstown Maryland 21133											
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cedar Hill Cemetery		DATE		20c. LOCATION — City or Town, State Baltimore MD									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Stephen M. Gentile				22. NAME AND ADDRESS OF FACILITY Loring Byers Funeral Directors, Inc 8728 Liberty Road Randallstown, MD 21133											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cerebral Vascular Accident DUE TO (OR AS A CONSEQUENCE OF): b. Atherosclerotic Coronary Artery Disease DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST												Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Aspiration Pneumonia												24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)											
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER Robert J. Moss				29c. LICENSE NUMBER 032882				29d. DATE SIGNED (Month, Day, Year) 3/5/91							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Robert Moss 249 Main Street Reisterstown, MD 21136															
31. DATE FILED (Month, Day, Year) MAR 05 1991				32. REGISTRAR'S SIGNATURE John Davidson-Randall											



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				91 05731					
CERTIFICATE OF DEATH				REG. NO.									
1. DECEDENT'S NAME (First, Middle, Last) <b>ROBERT F. BROWN</b>				2. DATE OF DEATH MONTH <b>2</b> DAY <b>28</b> YEAR <b>91</b>				3. TIME OF DEATH M					
4. SOCIAL SECURITY NUMBER <b>213 098286</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		8. AGE (In yrs. last birthday) <b>75</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) <b>3-24-15</b>		8. BIRTHPLACE (State or Foreign Country) <b>MD USA</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>BON SECOURS HOSP.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>				9c. COUNTY OF DEATH <b>CITY</b>					
10a. STATE <b>MD</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTIMORE, CITY</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
10e. STREET AND NUMBER <b>2519 GARRETT AVE.</b>				10f. ZIP CODE <b>21218</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>ARMY</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify <b>BLACK</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>STATE OF MARYLAND</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>STATE OF MARYLAND</b>				16b. KIND OF BUSINESS/INDUSTRY					
17. FATHER'S NAME (First, Middle, Last) <b>JOSEPH R. WALLACE</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>LETTIE BROWN</b>									
19a. INFORMANT'S NAME (Type/Print) <b>MARGARET C. WALLACE</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3007 ELGIN AVE./BALTIMORE, MD. 21216</b>									
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>GARRISON FOREST VET. CEM</b>				20c. LOCATION — City or Town, State <b>OWINGS MILLS, MD.</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Gladys Warner</b>				22. NAME AND ADDRESS OF FACILITY <b>WM.C. MARCH F.H. 1101 E. NORTH AVE.</b>									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Pneumonia</b> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.										Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Pneumonia, metabolic disorder, COPD, intestinal infarction</b>										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Jamir Evans MD</b>						29c. LICENSE NUMBER <b>D 20040</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/1/91</b>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Jamir Evans MD, 700 Worthington Blvd, Balto, MD 21201</b>													
31. DATE FILED (Month, Day, Year) <b>MAR 05 1991</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>									



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 91 05732

1. DECEDENT'S NAME (First, Middle, Last) JOHN L. BELLAMY				2. DATE OF DEATH MONTH DAY YEAR 3 2 91		3. TIME OF DEATH 7:30 A.M.	
4. SOCIAL SECURITY NUMBER 216-03-3972		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 85 YRS.	7. DATE OF BIRTH (Month, Day, Year) 08-23-05		8. BIRTHPLACE (State or Foreign Country) MD	
9a. FACILITY NAME (If not institution, give street and number) ST. JOSEPH HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH TOWSON		9c. COUNTY OF DEATH Baltimore	
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 306 Murdock Rd.				10f. ZIP CODE 21212		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 H.S. College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Engineer(Air Conditioning)		16b. KING OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) John M. Bellamy				18. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret Sorge			
19a. INFORMANT'S NAME (Type/Print) Blanche R. Bellamy				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 306 Murdock Rd. Baltimore, Maryland 21212			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Druid Ridge Cemetery		20c. LOCATION — City or Town, State Balto. Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert M. Kratz				22. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home 6500 York Rd. 21212			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sepsis Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. Urinary Tract Infection c. Prostatic Cancer d.						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atrial fibrillation, Atherosclerotic Coronary Vascular Disease, Multi-Infarct Dementia, and Cardiac Arrhythmia						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURED			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Chuang MD				29c. LICENSE NUMBER D36141		29d. DATE SIGNED (Month, Day, Year) 3-2-91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) TAWFIK CHAM, MD 2213 WOODBURN LANE, BALTIMORE, MD 21209							
31. DATE FILED (Month, Day, Year) MAR 05 1991		32. REGISTRAR'S SIGNATURE Julia Davidson-Randall					



1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05733

1. DECEDENT'S NAME (First, Middle, Last) <i>Mildred C. Belle</i>				2. DATE OF DEATH MONTH <i>3</i> DAY <i>1</i> YEAR <i>91</i>		3. TIME OF DEATH <i>9:50 P M</i>	
4. SOCIAL SECURITY NUMBER <i>219-22-3876A</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>69</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>5-20-</i>	
8. FACILITY NAME (If not institution, give street and number) <i>Univ of Maryland Hosp</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i>		9c. COUNTY OF DEATH <i>Baltimore</i>	
RESIDENCE OF DECEDENT							
10a. STATE <i>MD</i>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <i>Balto</i>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <i>1146 Myrtle Ave</i>				10f. ZIP CODE <i>21201</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (14 or 5+) <input type="checkbox"/>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Delacy Elam</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Archie R. Belle</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1146 Myrtle Ave Balto, MD 21201</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Loudon Park Cem</i>		20c. LOCATION — City or Town, State <i>Balto, MD</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Gala March</i>				22. NAME AND ADDRESS OF FACILITY <i>March F.H. West 4300 Wabash Ave</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>Lung Cancer with metastases</i> DUE TO (OR AS A CONSEQUENCE OF):					
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. DUE TO (OR AS A CONSEQUENCE OF):					
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Renal Failure</i>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> 1 <input type="checkbox"/> YES <input type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Jack A Colazzo MD</i>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <i>3/1/91</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Jack A Colazzo MD - Univ of Maryland Hosp - 22 S Greene St, Balto MD</i>							
31. DATE FILED (Month, Day, Year) <i>MAR 05 1991</i>		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





91-1115-510

91 05734

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MARGARET L. BAYNOR</b>				2. DATE OF DEATH MONTH <b>02</b> DAY <b>26</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>8:37</b> p.m.	
4. SOCIAL SECURITY NUMBER <b>213-20-4247</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>65</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>7-19-1925</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>BON SECOUR HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		9c. COUNTY OF DEATH <b>BALTIMORE</b>	
10a. STATE <b>Md</b>				10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>2408 Baker Street</b>			
10f. ZIP CODE <b>21216</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U S A</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <b>David Williams</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Jennie Hall</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Warren Baynor</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2408 Baker Street Balto, Md 21216</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Garrison Forest Vet</b>		DATE <b>3/4/91</b>		20c. LOCATION — City or Town, State <b>Owings Mills, Md</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Gala March</i>				22. NAME AND ADDRESS OF FACILITY <b>March F/H West</b> <b>4300 Wabash Avenue</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Arteriosclerotic Cardiovascular Disease</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>b. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>c. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>d. DUE TO (OR AS A CONSEQUENCE OF):</b>							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Carcinoma of cervix</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <b>INQUIRY</b>
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Margaret A. Kozak</i>				29c. LICENSE NUMBER <b>OCME</b>		29d. DATE SIGNED (Month, Day, Year) <b>02/27/1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MARGARET A. KOZAK 111 PENN STREET BALTIMORE, MARYLAND 21201</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 05 1991</b>				32. REGISTRAR'S SIGNATURE <i>Gale Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05735

1. DECEDENT'S NAME (First, Middle, Last) Roger Butler				2. DATE OF DEATH MONTH 2 DAY 26 YEAR 91		3. TIME OF DEATH 8:02 p M					
4. SOCIAL SECURITY NUMBER 578-68-9349		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 41 YRS.		7. DATE OF BIRTH (Month, Day, Year) 8/16/49		8. BIRTHPLACE (State or Foreign Country) DC			
9a. FACILITY NAME (If not institution, give street and number) 4313 N Addison Rd				9b. CITY, TOWN OR LOCATION OF DEATH Capitol Heights			9c. COUNTY OF DEATH PG				
RESIDENCE OF DECEDENT				10a. STATE Md		10b. COUNTY PG		10c. CITY, TOWN OR LOCATION Capitol Heights			
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 4313 N Addison Rd		10f. ZIP CODE 20743		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Yrs		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Postal Service		16b. KIND OF BUSINESS/INDUSTRY							
17. FATHER'S NAME (First, Middle, Last) William T Butler Sr				18. MOTHER'S NAME (First, Middle, Maiden Surname) Verene White							
19a. INFORMANT'S NAME (Type/Print) Verene Hughes				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1809 Kenyon St NW, DC 20010							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Lincoln Memorial		20c. LOCATION — City or Town, State Suitland, Md							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Juan Smiel				22. NAME AND ADDRESS OF FACILITY John T Rhines Co., Inc 3015 12th St NE, DC 20017							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acquire Immune Deficiency Syndrome Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER Robert M. Thomas MD						29c. LICENSE NUMBER CS9106699		29d. DATE SIGNED (Month, Day, Year) 2/27/91			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 916 19th St NW Suit 402, Washington, DC											
31. DATE FILED (Month, Day, Year) MAR 5 1991				32. REGISTRAR'S SIGNATURE John Davidson Randall							



91 05736

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Jonathan Joseph Beeker</b>				2. DATE OF DEATH MONTH <b>1</b> DAY <b>27</b> YEAR <b>91</b>		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>1 27 91</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>
9a. FACILITY NAME (If not Institution, give street and number) <b>Greater Baltimore Medical Center</b>			9b. CITY, TOWN OR LOCATION OF DEATH <b>Towson</b>			9c. COUNTY OF DEATH <b>Baltimore</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>3201 East Joppa Road</b>				10f. ZIP CODE <b>21234</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>N/A</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>N/A</b> College (1-4 or 5+) <b>N/A</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>N/A</b>		16b. KIND OF BUSINESS/INDUSTRY <b>N/A</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Gary J. Brockmeyer</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Nancy M. Beeker</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Nancy M. Beeker</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3201 E. Joppa Road, Towson, Md. 21204</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metro Crematory</b>		20c. LOCATION — City or Town, State <b>Catonsville, Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Paul T. Lochstampf</b>				22. NAME AND ADDRESS OF FACILITY <b>Lemmon-Mitchell-Wiedefeld Timonium, Maryland 21093</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) →  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST						Approximate interval Between Onset and Death	
a. <b>Immaturity - 20 week gestation - 249 grams</b> DUE TO (OR AS A CONSEQUENCE OF):							
b. <b>Small for gestational age</b> DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — A1 home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Howard L Siegel MD</b>				29c. LICENSE NUMBER <b>D28885</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/08/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Howard L. Siegel, M.D. GBMC, 6701 N. Charles St., Baltimore, MD 21204</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 05 1991</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



REG. NO.

OHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

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DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

91 05738  
REG. NO.

1. DECEASED'S NAME (First, Middle, Last) VIVIAN BRANSON				2. DATE OF DEATH MONTH DAY YEAR MARCH 3 1991		3. TIME OF DEATH 10:32 a.m.			
4. SOCIAL SECURITY NUMBER 301-22-2517		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (in yrs. last birthday) 71 YRS.		7. DATE OF BIRTH (Month, Day, Year) 9-8-19		8. BIRTHPLACE (State or Foreign Country) West Virginia	
9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY			9c. COUNTY OF DEATH BALTIMORE CITY		
10a. STATE Maryland		10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore City			10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		
10e. STREET AND NUMBER 1305 Mantle Street				10f. ZIP CODE 21234		10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: NEGROID			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade		15b. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) housewife		15c. KIND OF BUSINESS/INDUSTRY none					
17. FATHER'S NAME (First, Middle, Last) James Lincoln				18. MOTHER'S NAME (First, Middle, Maiden Surname) Elsie Bates					
19a. INFORMANT'S NAME (Type/Print) Katherine Winkler				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1221 Cochran Avenue, Balto, Md. 21239					
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Greenmount Cemetery		20c. LOCATION — City or Town, State Baltimore, Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Calvin B. Scruggs Jr.		22. NAME AND ADDRESS OF FACILITY Calvin B. Scruggs Funeral Home 1412 E. Preston St. Balto, Md. 21218							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Intracardiac Conduction Block (1 day) day a. DUE TO (OR AS A CONSEQUENCE OF): b. Myocarditis (Myocarditis) (3 days) 3 days c. DUE TO (OR AS A CONSEQUENCE OF): d. SEQUENTIALLY list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Pneumonia (Pneumonia)								Approximate Interval Between Onset and Death	
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER William Barton, MD				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) 3/3/91			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) William Barton, 600 N. Wolfe St. Baltimore MD 21205									
31. DATE FILED (Month, Day, Year) 3/3/91 MAR 05 1991				32. REGISTRAR'S SIGNATURE Julia Davidson-Rendell					



91 05739

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Evelyn R. Carey				2. DATE OF DEATH MONTH 3 DAY 04 YEAR 91		3. TIME OF DEATH 10:15 A M	
4. SOCIAL SECURITY NUMBER 219-10-9430 A		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 70 YRS.		7. DATE OF BIRTH (Month, Day, Year) 12/22/20	
9a. FACILITY NAME (If not institution, give street and number) Balto. Co. General Hosp.				9b. CITY, TOWN OR LOCATION OF DEATH Randallstown		9c. COUNTY OF DEATH Baltimore	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Pikesville		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 20 Brightside Ave.				10f. ZIP CODE 21208		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7th College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) Patrick Callary				18. MOTHER'S NAME (First, Middle, Maiden Surname) Fannie Bull			
19a. INFORMANT'S NAME (Type/Print) Mr. Thomas H. Carey				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 Cinnamon Circle Apt. 1D Randallstown, MD 21133			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) Entombment		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Druid Ridge Mausoleum		DATE		20c. LOCATION — City or Town, State Pikesville, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Stephen M. Jenkins</i>				22. NAME AND ADDRESS OF FACILITY Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Pneumonia</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Severe COPD</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST						Approximate Interval Between Onset and Death <i>weeks</i> <i>years</i>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>reactive depression w/ husband's death</i>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>B. K. Hoff MD</i>				29c. LICENSE NUMBER <i>D19261</i>		29d. DATE SIGNED (Month, Day, Year) <i>3/4/91</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>B. K. Hoff MD 10085 Red Run Blvd Owings Mills MD</i>							
31. DATE FILED (Month, Day, Year) <i>MAR 05 1991</i>		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91-1165-510

91 05740

FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Frozine Coe</b>				2. DATE OF DEATH MONTH DAY YEAR <b>03 02 1991</b>		3. TIME OF DEATH <b>10:21 A M</b>	
4. SOCIAL SECURITY NUMBER <b>439-32-1516</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>81</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>4-9-09</b>	
8. BIRTHPLACE (State or Foreign Country) <b>MISS</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Sinai Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>	
9c. COUNTY OF DEATH				10a. STATE <b>MD.</b>		10b. COUNTY	
10c. CITY, TOWN OR LOCATION <b>BALTO.</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>5400 Relcrest Rd</b>	
10f. ZIP CODE <b>21206</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Negro</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) <input checked="" type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <b>Albert Daniels</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>SARAH Chapman</b>			
19a. INFORMANT'S NAME (Type/Print) <b>PATRICIA</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2524 E. Biddle St. BALTO. MD.</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>WESTERN STAR Cem. Co. BALTO. MD.</b>		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Betts Funeral Home</b>				22. NAME AND ADDRESS OF FACILITY <b>1129 W. Caroline St.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Atherosclerotic Cardiovascular Disease</b> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)	
28b. TIME OF INJURY <b>M</b>				28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>A.M. Dixon</b>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>03 03 1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>A.M. Dixon 111 Penn Street, Baltimore Maryland 21201</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 05 1991</b>				32. REGISTRAR'S SIGNATURE <b>Jake Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



BRITISH MUSEUM

Vol. 12, Part 2

1912

1 - FOR  
STATE  
REGISTRAR

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

**IMPORTANT:** If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEDENT'S NAME (First, Middle, Last) <b>GERTRUDE M. CAIN</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>-3-</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>2:00A</b>	
4. SOCIAL SECURITY NUMBER <b>212-09-6563</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>80</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>07/15/10</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>ST Joseph Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Towson MD</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Parkville</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>8318C Nunley Drive</b>			
10f. ZIP CODE <b>21234</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 Years</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Secretary</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Baltimore City Dept. of Education</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Joseph F. Matz, Sr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Margaret Zang</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Bernadette Metz</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3801 Loch Raven Blvd. Baltimore, Md. 21218</b>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Most Holy Redeemer Cemetery</b>		20c. LOCATION — City or Town, State <b>Baltimore, Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>James F. Burnside, Jr.</b>		22. NAME AND ADDRESS OF FACILITY <b>Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Baltimore, Md. 21212</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>SEPSIS</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF): <b>Peritonitis 2° to Perforated diverticulitis</b>  b. DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Edmondo A. Ruelas</b>				29c. LICENSE NUMBER <b>0-24710</b>		29d. DATE SIGNED (Month, Day, Year) <b>3-3-91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>910 ST. JOSEPH HOSPITAL, 7620 YORK RD, TOWSON MD 21204</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 05 1991</b>		32. REGISTRAR'S SIGNATURE <b>John Davidson-Rendell</b>					





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				91 05742			
CERTIFICATE OF DEATH				REG. NO.							
1. DECEASED'S NAME (First, Middle, Last) FRANK B. CARTER SR				2. DATE OF DEATH MONTH DAY YEAR 03 01 91		3. TIME OF DEATH 8:30 AM					
4. SOCIAL SECURITY NUMBER 218-14-7487		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 96 YRS.	7. DATE OF BIRTH (Month, Day, Year) 07-05-1894		8. BIRTHPLACE (State or Foreign Country) Va					
9a. FACILITY NAME (If not institution, give street and number) Liberty Medical Center				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH					
10a. STATE Md				10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER 1565 Richland St				10f. ZIP CODE 21217		10g. CITIZEN OF WHAT COUNTRY? U.S.A					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY					
17. FATHER'S NAME (First, Middle, Last) Daniel Carter				18. MOTHER'S NAME (First, Middle, Maiden Surname) Elizabeth							
19a. INFORMANT'S NAME (Type/Print) Frank B. Carter				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4323 Elders Rd Baltimore, Md 21215							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Arbutus Mem Park 3/5/91		20c. LOCATION — City or Town, State Arbutus, Md							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dale March				22. NAME AND ADDRESS OF FACILITY Mary F. H. West 4310 Wabash Ave							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SEPTIC SHOCK 2° GANGRENE FEET DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. ARTERIOSCLEROTIC HEART DISEASE. DUE TO (OR AS A CONSEQUENCE OF): c. DEHYDRATION. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. BILATERAL CHRONIC SUBDURAL HAEMATOMA RENAL INSUFFICIENCY								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER Sudhir D. Patel				29c. LICENSE NUMBER D 23300		29d. DATE SIGNED (Month, Day, Year) 3.1.91					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SUDHIR D. PATEL 2600 Liberty Rd. Bal. Md. 21215											
31. DATE FILED (Month, Day, Year) MAR 05 1991				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall							

1. The first part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom. It is shown that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are in agreement with the experimental facts.

2. The second part of the paper is devoted to a discussion of the specific properties of the atom. It is shown that the specific properties of the atom are determined by the laws of quantum mechanics, and that the laws of quantum mechanics are in agreement with the experimental facts.




3. The third part of the paper is devoted to a discussion of the applications of the theory of the structure of the atom. It is shown that the theory of the structure of the atom has many important applications in physics and chemistry.

THEORY OF THE STRUCTURE OF THE ATOM  
BY  
J. J. THOMSON  
AND  
P. A. M. DIRAC

91 05743

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Elizabeth Agnes Chaffman</b>				2. DATE OF DEATH MONTHS <b>3</b> DAY <b>4</b> YEAR <b>91</b>		3. TIME OF DEATH <b>3:15 A M</b>	
4. SOCIAL SECURITY NUMBER <b>219-30-8578</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>86</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>02/24/05</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>St. Agnes Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>411 Northbend Road</b>			
10f. ZIP CODE <b>21229</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>sec.</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Oil Company</b>			
17. FATHER'S NAME (First, Middle, Last) <b>John A. Knell</b>				16. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Margaret Kunz</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Margaret A. Baquol</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>411 Northbend Road, Apt. H, Baltimore, Maryland 21229</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>New Cathedral Cemetery</b>		20c. LOCATION — City or Town, State <b>Baltimore, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Ambrose Funeral Home, Inc. 1328 Sulphur Spring Road, Arbutus, Md. 21227</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CONGESTIVE HEART FAILURE - LONG STANDING.</b>  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <b>ADVANCE ARTERIO-SCLEROTIC CARDIOVASCULAR</b>  <b>CELLULITIS - SEPSIS</b> </div> <div style="width: 35%;"> <b>3 months</b> </div> </div>							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)	
28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER  <b>RESIDENT</b>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>MAR 05 1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>ASUMANI YEBRAH. MD, 51 ASNER #036, 900 CATON AVE, BALTIMORE, MD 21229</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 05 1991</b>		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician to the FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				91 05744							
CERTIFICATE OF DEATH				REG. NO.											
1. DECEDENT'S NAME (First, Middle, Last) <u>Giorgio (George) Caroppo</u>				2. DATE OF DEATH MONTH <u>3</u> DAY <u>1</u> YEAR <u>91</u>				3. TIME OF DEATH <u>3:00 P.M.</u>							
4. SOCIAL SECURITY NUMBER <u>219-34-1865</u>		5. SEX <u>M</u>		6. AGE (In yrs. last birthday) <u>76</u> YRS.		7. DATE OF BIRTH MONTH <u>2</u> DAY <u>9</u> YEAR <u>1915</u>		8. BIRTHPLACE (State or Foreign Country) <u>Italy</u>							
9a. FACILITY NAME (If not institution, give street and number) <u>Francis Scott Key M.C.</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>Baltimore</u>				9c. COUNTY OF DEATH <u></u>							
10a. STATE <u>Maryland</u>		10b. COUNTY <u></u>		10c. CITY, TOWN OR LOCATION <u>Baltimore</u>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER <u>125 S. Cator Street</u>				10f. ZIP CODE <u>21224</u>				10g. CITIZEN OF WHAT COUNTRY? <u>Italy</u>							
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>13th</u> College (14 or 6+) <u></u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Milk Employer</u>				16b. KIND OF BUSINESS/INDUSTRY <u>Dairy Company</u>									
17. FATHER'S NAME (First, Middle, Last) <u>Caroppo</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>UNKNOWN</u>											
19a. INFORMANT'S NAME (Type Print) <u>Anthony De Angelo</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>601 Thomas Way Clark H Belair Md. 21014</u>											
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>CARROLLS OF FAITH</u>		DATE <u>3-1-91</u>		20c. LOCATION — City or Town, State <u>BALTO. MD.</u>									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>[Signature]</u>				22. NAME AND ADDRESS OF FACILITY <u>Joseph N. Zannino Jr. F.H. 263 S. Conkling St. Baltimore Md 21204</u>											
23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Respiratory Arrest.</u>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <u>LUNG CANCER</u> b. <u></u> c. <u></u> d. <u></u>								Approximate Interval Between Onset and Death							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Left Hemiparesis Since</u>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)													
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <u></u>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED							
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										29b. SIGNATURE AND TITLE OF CERTIFIER <u>[Signature] M.D.</u>		29c. LICENSE NUMBER <u>FA03</u>		29d. DATE SIGNED (Month, Day, Year) <u>03/01/91</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>Barry C. Thresh M.D.</u>															
31. DATE FILED (Month, Day, Year) <u>MAR 5 1991</u>				32. REGISTRAR'S SIGNATURE <u>Julia Davidson-Bondell</u>											



2 248 24 68 A  
CHERNISKY, JOHN  
06/24/36 JR.

91 05745

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH  
REG. NO.

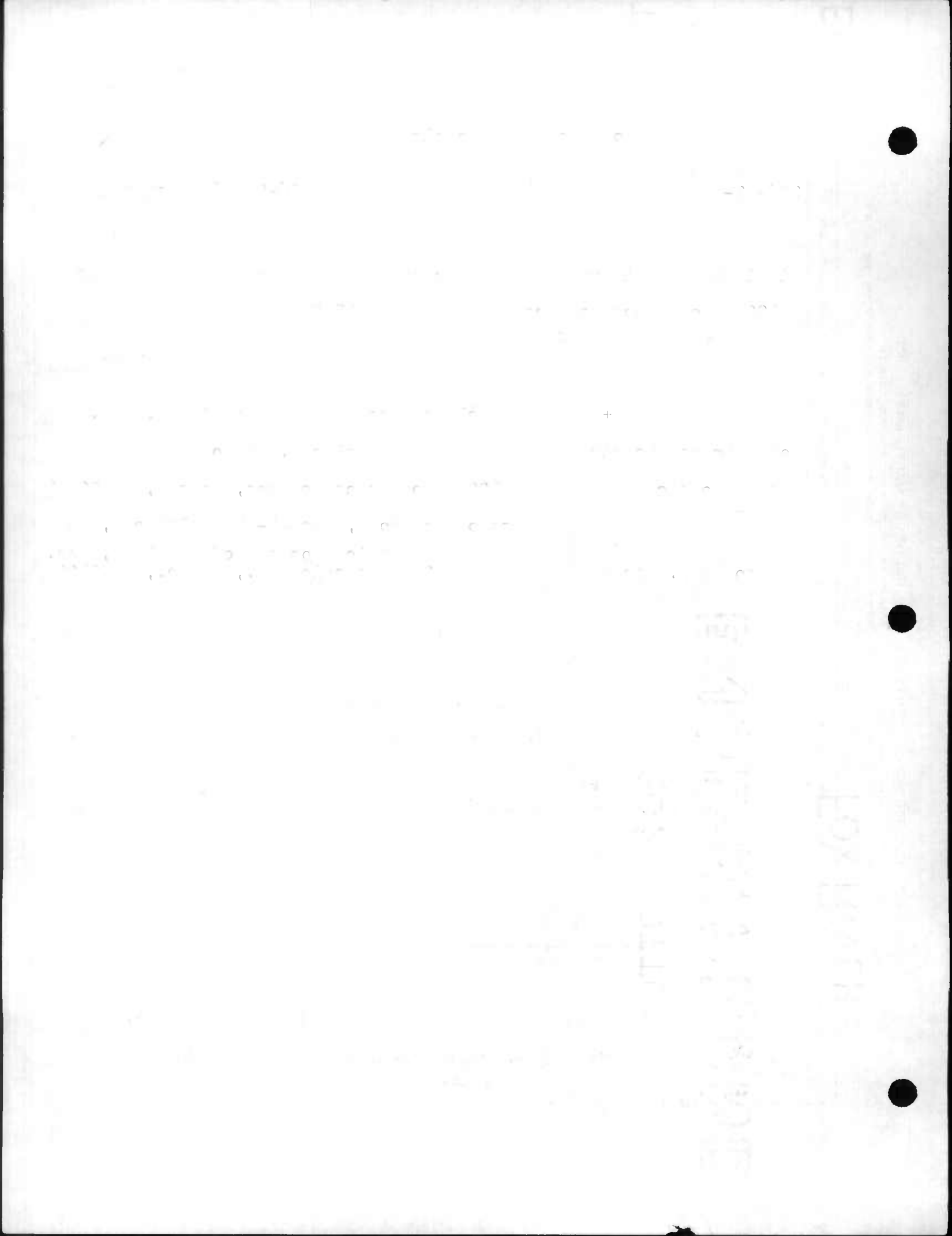
1. DECEDENT'S NAME (First, Middle, Last) <b>John Bernard Chernisky</b>				2. DATE OF DEATH MONTH DAY YEAR <b>MARCH 3 1991</b>		3. TIME OF DEATH <b>3:10 a.m.</b>											
4. SOCIAL SECURITY NUMBER <b>296-32-4908</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>54</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>06-24-36</b>											
8. BIRTHPLACE (State or Foreign Country) <b>Pennsylvania</b>				9a. FACILITY NAME (If not institution, give street and number) <b>THE JOHNS HOPKINS HOSPITAL</b>													
9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>				9c. COUNTY OF DEATH <b>BALTIMORE CITY</b>													
10a. STATE <b>Virginia</b>				10b. COUNTY <b>Fairfax</b>		10c. CITY, TOWN OR LOCATION <b>McLean</b>											
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>1223 Providence Terrace</b>													
10f. ZIP CODE <b>22101</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>													
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>											
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5 +</b> College (1-4 or 5+) <b>5 +</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Civil Engineer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Federal Hwy. Adm.</b>											
17. FATHER'S NAME (First, Middle, Last) <b>John Thomas Chernisky</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Helen C. Rerko</b>													
19a. INFORMANT'S NAME (Type/Print) <b>Linda Chernisky</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1223 Providence Terrace, McLean, VA 22101</b>													
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metro Crematory, Inc 3-4-91</b>		DATE <b>Baltimore, MD</b>		20c. LOCATION — City or Town, State											
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>George E. MacNabb</b>				22. NAME AND ADDRESS OF FACILITY <b>Cremation Society of Maryland, Inc. 299 Frederick Rd., Balto., MD 21228</b>													
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <table border="1"><thead><tr><th>IMMEDIATE CAUSE (Final disease or condition resulting in death)</th><th>Approximate Interval Between Onset and Death</th></tr></thead><tbody><tr><td>a. <b>Hepatic failure</b> DUE TO (OR AS A CONSEQUENCE OF):</td><td><b>3 mos</b></td></tr><tr><td>b. <b>Renal failure</b> DUE TO (OR AS A CONSEQUENCE OF):</td><td><b>1 mo</b></td></tr><tr><td>c. <b>Cerebral edema - metabolic</b> DUE TO (OR AS A CONSEQUENCE OF):</td><td><b>2 days</b></td></tr><tr><td>d. <b>ARDS - Pulmonary</b> DUE TO (OR AS A CONSEQUENCE OF):</td><td><b>1 mo</b></td></tr></tbody></table> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								IMMEDIATE CAUSE (Final disease or condition resulting in death)	Approximate Interval Between Onset and Death	a. <b>Hepatic failure</b> DUE TO (OR AS A CONSEQUENCE OF):	<b>3 mos</b>	b. <b>Renal failure</b> DUE TO (OR AS A CONSEQUENCE OF):	<b>1 mo</b>	c. <b>Cerebral edema - metabolic</b> DUE TO (OR AS A CONSEQUENCE OF):	<b>2 days</b>	d. <b>ARDS - Pulmonary</b> DUE TO (OR AS A CONSEQUENCE OF):	<b>1 mo</b>
IMMEDIATE CAUSE (Final disease or condition resulting in death)	Approximate Interval Between Onset and Death																
a. <b>Hepatic failure</b> DUE TO (OR AS A CONSEQUENCE OF):	<b>3 mos</b>																
b. <b>Renal failure</b> DUE TO (OR AS A CONSEQUENCE OF):	<b>1 mo</b>																
c. <b>Cerebral edema - metabolic</b> DUE TO (OR AS A CONSEQUENCE OF):	<b>2 days</b>																
d. <b>ARDS - Pulmonary</b> DUE TO (OR AS A CONSEQUENCE OF):	<b>1 mo</b>																
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Listeria peritonsillaris</b> <b>Staphylococcus pneumoniae</b> <b>Campylobacter</b>																	
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)													
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO											
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)													
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																	
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Daniel W. Allen MD</b>				29c. LICENSE NUMBER <b>E9814</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/3/91</b>											
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Daniel W. Allen MD Johns Hopkins Hospital - Int. Medicine</b>																	
31. DATE FILED (Month, Day, Year) <b>MAR 05 1991</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>													

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





91 05746

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) GLADYS VIOLA CARTER				2. DATE OF DEATH MONTH DAY YEAR 03 01 1991		3. TIME OF DEATH 12:00 PM	
4. SOCIAL SECURITY NUMBER 214-44-5514		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 89 YRS.		7. DATE OF BIRTH (Month, Day, Year) 8-12-1901	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) 707 WELLHAM AVE.		9b. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE	
9c. COUNTY OF DEATH ANNE ARUNDEL				10a. STATE MD		10b. COUNTY ANNE ARUNDEL	
10c. CITY, TOWN OR LOCATION GLEN BURNIE				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 707 Wellham Ave.	
10f. ZIP CODE 21061				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11th College (1-4 or 5+) None				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home	
17. FATHER'S NAME (First, Middle, Last) Howard Bolgiano				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ella Briscoe			
19a. INFORMANT'S NAME (Type/Print) Charles E. Carter				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same As 10			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Moreland Memorial Park 3-4		20c. LOCATION — City or Town, State Baltimore, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE R. Henry Hopkins				22. NAME AND ADDRESS OF FACILITY SINGLETON FUNERAL HOME 1 SECOND AVE. S.W. GLEN BURNIE, MD 21061			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CORONARY ARTERY DISEASE Arterio Sclerotic Heart Disease, General DUE TO (OR AS A CONSEQUENCE OF): Anteriosclerotic 1 1/2 yrs Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Carcinoma left breast DUE TO (OR AS A CONSEQUENCE OF): is another but not significant c. Condition in this case d.				Approximate Interval Between Onset and Death 20 yrs 1 1/2 yrs			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29c. LICENSE NUMBER D10820		29d. DATE SIGNED (Month, Day, Year) 3/1/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Joseph Taler 950 Aqueduct Rd Glen Burnie Md 21061				31. DATE FILED (Month, Day, Year) MAR 5 1991			
32. REGISTRAR'S SIGNATURE John Davidson-Randall							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 05747

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. <b>Lenore</b> <b>LENORA L. DEVON</b>				2. DATE OF DEATH <b>3-2-91</b> MONTH DAY YEAR		3. TIME OF DEATH <b>1 9 M</b>	
4. SOCIAL SECURITY NUMBER <b>215-22-3191</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>87</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>NOV. 8 1903</b>	
8. BIRTHPLACE (State or Foreign Country) <b>WISCONSIN</b>							
9a. FACILITY NAME (If not institution, give street and number) <b>GOOD SAMARITAN HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		9c. COUNTY OF DEATH <b>---</b>	
10a. STATE <b>MD.</b>		10b. COUNTY <b>---</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>3902 CHESTERFIELD AVENUE</b>				10f. ZIP CODE <b>21213</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) <b>N/A</b> College (1-4 or 5+) <b>N/A</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>BEAUTICIAN</b>		16b. KIND OF BUSINESS/INDUSTRY <b>BEAUTY SHOP</b>			
17. FATHER'S NAME (First, Middle, Last) <b>GUSTAV KOEPKE</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>AUGUSTA ERDMAN</b>			
19a. INFORMANT'S NAME (Type/Print) <b>ELIZABETH J. JACK (NIECE)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3310 SPRING LANE, FALLS CHURCH, VA. 22041</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>GARDENS OF FAITH CEMETERY</b>		20c. LOCATION — City or Town, State <b>BALTIMORE, MD.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>SCHIMUNEK FUNERAL HOME INC. 3331 Brehms Lane, Baltimore, Md. 21213</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Metastatic ca c brain + liver metastases</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF):  b. DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d.						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, tectory, office building, etc. (Specify)			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>P. Mathias, MD</b>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>▶</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) <b>MAR 05 1991</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				91 05748							
CERTIFICATE OF DEATH				REG. NO.											
1. DECEDENT'S NAME (First, Middle, Last) <b>MARGARET E. DEAMER</b>				2. DATE OF DEATH MONTH <b>03</b> DAY <b>04</b> YEAR <b>1991</b>				3. TIME OF DEATH <b>730 A</b> M							
4. SOCIAL SECURITY NUMF <b>578-07-8594</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (in yrs. last birthday) <b>86</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) <b>03-22-1904</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Francis Scott Key Medical Center</b>						9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>				9c. COUNTY OF DEATH					
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Baltimore</b>				10c. CITY, TOWN OR LOCATION <b>Edgemere</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER <b>2907 Delmar Avenue</b>						10f. ZIP CODE <b>21219</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>12th Grade</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>							
17. FATHER'S NAME (First, Middle, Last) <b>Howard E. Riddlemoser</b>						18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Emma Keller</b>									
19a. INFORMANT'S NAME (Type/Print) <b>Francis Deamer</b>						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2907 Delmar Avenue, Baltimore, MD 21219</b>									
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Cedar Hill Cemetery 3/7/91</b>				20c. LOCATION — City or Town, State <b>Washington D.C.</b>									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Chad W. Fisher</b>				22. NAME AND ADDRESS OF FACILITY <b>Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue, Baltimore, MD 21222</b>											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Renal Failure</b>  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. <b>Multiple Myeloma</b> DUE TO (OR AS A CONSEQUENCE OF):  b. DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d. DUE TO (OR AS A CONSEQUENCE OF):										Approximate Interval Between Onset and Death					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)											
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Robert J. Bresnahan</b>						29c. LICENSE NUMBER <b>MA D1559</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/4/91</b>							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>K. Von Eiken MD, FSKMC, 4940 Eastern Ave Balt.</b>															
31. DATE FILED (Month, Day, Year) <b>MAR 5 1991</b>				32. REGISTRAR'S SIGNATURE <b>J. A. Davidson</b>											

FOR BUREAU

EX-111-11111

11111

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				91 05749			
CERTIFICATE OF DEATH				REG. NO.							
1. DECEDENT'S NAME (First, Middle, Last) Ernest George DIMICK				2. DATE OF DEATH MONTH 3 DAY 2 YEAR 1991				3. TIME OF DEATH 11:15 a.m.			
4. SOCIAL SECURITY NUMBER 213-09-0960		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 86 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Dec. 24, 1904		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) Franklin Square Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Rossville				9c. COUNTY OF DEATH Baltimore County			
RESIDENCE OF DECEDENT											
10a. STATE Md.		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Essex				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 419 Walnut Grove Road				10f. ZIP CODE 21221				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2yrs				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Machinist				16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) John Adam Dimick				18. MOTHER'S NAME (First, Middle, Maiden Surname) Annie Barthol							
19a. INFORMANT'S NAME (Type/Print) Doris Bantz				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 419 Walnut Grove Road Baltimore Md. 21221							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Oak Lawn Cemetery 3/6/91		DATE		20c. LOCATION — City or Town, State Baltimore Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Connelly Funeral Home				22. NAME AND ADDRESS OF FACILITY Connelly Funeral Home 300 Mace Ave. 21221							
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Anoxic Encephalopathy DUE TO (OR AS A CONSEQUENCE OF):  Seizure Disorder DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d.  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension Syncope of unknown etiology								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER Joyce E. King M.D.				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) 3/2/91					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) Joyce King, M.D. 9000 Franklin Square Drive Baltimore 21237											
31. DATE FILED (Month, Day, Year) MAR 05 1991				32. REGISTRAR'S SIGNATURE John F. Davidson-Randall							





DHMH-16 Rev 1/89

FOX RIVER

ENGINEERING FIRM

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05751

1. DECEDENT'S NAME (First, Middle, Last) <b>Paul Henry Doering</b>				2. DATE OF DEATH MONTH DAY YEAR <b>March 4, 1991</b>		3. TIME OF DEATH <b>7:35pm M</b>			
4. SOCIAL SECURITY NUMBER <b>216-07-3435</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>72 YRS.</b>		7. DATE OF BIRTH (Month, Day, Year) <b>March 16, 1918 Md.</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Francis Scott Key Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH			
10a. STATE <b>Md.</b>				10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Essex</b>			
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>606 Almond Ave.</b>		10f. ZIP CODE <b>21221</b>			
10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES			
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY					
17. FATHER'S NAME (First, Middle, Last) <b>George Doering</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Elizabeth Borgmann</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Dolores Doering</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>606 Almond Ave. Baltimore Md. 21221</b>					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Woodlawn Cemetery 3/7/91</b>		20c. LOCATION — City or Town, State <b>Baltimore Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Connelly Funeral Home</b>				22. NAME AND ADDRESS OF FACILITY <b>ConnellyFuneralHome 300MAceAve.Balto.</b>					
23. PART I. Enter the disease(s), or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Sepsis</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <b>Bleeding Duodenal Ulcer</b> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic Atrial Fibrillation with Rapid Vent. Resp.</b>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>			
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED					
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <b>[Signature] MD</b>		29c. LICENSE NUMBER <b>008547</b>			
29d. DATE SIGNED (Month, Day, Year) <b>3/4/91</b>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)					
31. DATE FILED (Month, Day, Year) <b>MAR 05 1991</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>					



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05752

1. DECEDENT'S NAME (First, Middle, Last) <b>PATRICIA ANN DUFFY</b>				2. DATE OF DEATH MONTH <b>2</b> DAY <b>19</b> YEAR <b>'91</b>		3. TIME OF DEATH M					
4. SOCIAL SECURITY NUMBER <b>219-32-7068</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>53</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>8/26/37</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>2602 Baurenschmidt Drive</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Essex, Md.</b>				9c. COUNTY OF DEATH <b>Baltimore</b>			
RESIDENCE OF DECEDENT											
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Essex</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER <b>2602 Baurenschmidt Drive</b>				10f. ZIP CODE <b>21221</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Sect'y</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Eastern Ind. Med. Center</b>					
17. FATHER'S NAME (First, Middle, Last) <b>Thomas L. McGinnis</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Sophia Pachoski</b>							
19a. INFORMANT'S NAME (Type/Print) <b>John M. Duffy</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2602 Baurenschmidt Drive, Balto., Md. 21221</b>							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>2/22/91 - St. Stanislaus</b>		20c. LOCATION — City or Town, State <b>Baltimore, Md.</b>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Walter Dabrowski</b>				22. NAME AND ADDRESS OF FACILITY <b>Walter Dabrowski Funeral Chapel 1005 Dundalk Avenue, Baltimore, Md. 21224</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Metastatic Breast Carcinoma</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Chandra P. Belan MD</b>						29c. LICENSE NUMBER <b>30428</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/19/91</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>CHANDRA P. BELAN MD 22 S. GREENB STREET, BALTO MD 21201</b>											
31. DATE FILED (Month, Day, Year) <b>MAR 05 1991</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>							





91 05753

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Nora E. Dolinowski				2. DATE OF DEATH MONTH DAY YEAR 3 1 91		3. TIME OF DEATH 11:57 PM	
4. SOCIAL SECURITY NUMBER 213-10-3363		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 71 YRS.		7. DATE OF BIRTH (Month, Day, Year) 02-23-20	
8. BIRTHPLACE (State or Foreign Country) Virginia				9a. FACILITY NAME (If not institution, give street and number) Union Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City	
9c. COUNTY OF DEATH				10. RESIDENCE OF DECEDENT			
10a. STATE Maryland		10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 3415 Harford Rd.				10f. ZIP CODE 21218		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Cashier		16b. KIND OF BUSINESS/INDUSTRY Grocery Store			
17. FATHER'S NAME (First, Middle, Last) Elmer V. B. Morgan				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mattie Hundley			
19a. INFORMANT'S NAME (Type/Print) Kenneth E. Stermer, Sr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 169 Carvel Beach Rd., Baltimore, MD. 21226			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Moreland Memorial Park		20c. LOCATION — City or Town, State Parkville MD.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY ROBERT C. ALTENBURG FUNERAL HOME, INC. 6009 Harford Rd., Baltimore, MD. 21214			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. S/P MI & Post MI Angina & Prob. Extension DUE TO (OR AS A CONSEQUENCE OF): b. Acute Renal Failure DUE TO (OR AS A CONSEQUENCE OF): c. Resp Failure 2° Pulm Congestion DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Bronchospasm & Resp. Arrest							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> Resident				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) 3/1/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Marsha Y Blakeslee DO Union Mem Hosp Balto MD							
31. DATE FILED (Month, Day, Year) MAR 05 1991				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





91-1140-510

91 05754

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Theodore Herbert Elliott</b>						2. DATE OF DEATH MONTH <b>02</b> DAY <b>28</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>9:13 P M</b>	
4. SOCIAL SECURITY NUMBER <b>578 18 5970</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>76</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>1/12/1915</b>		8. BIRTHPLACE (State or Foreign Country) <b>Baltimore</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>3221 Gwynns Falls Parkway</b>						9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>		9c. COUNTY OF DEATH	
10a. STATE <b>MD</b>						10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO						10e. STREET AND NUMBER <b>3221 GWYNN FALLS PARKWAY</b>		10f. ZIP CODE <b>21216</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>						11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>YES</b>	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input type="checkbox"/> NO Specify: <b>NO</b>						14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 +</b> College (1-4 or 5+) <b>4 years</b>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Retired</b>						16b. KIND OF BUSINESS/INDUSTRY <b>Chemistist/Newspaper Bus</b>		17. FATHER'S NAME (First, Middle, Last) <b>JOHN ELLIOTT</b>	
18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>HALLIE HUNTER</b>						19a. INFORMANT'S NAME (Type/Print) <b>Ms Wendy Robinson Cousin</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3804 W. Rogers Avenue Main Entrance, Balto MD21215</b>	
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)						20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ronald Wade, Dir</i> <b>3/4/91</b>						22. NAME AND ADDRESS OF FACILITY <b>STATE ANATOMY BOARD</b> <b>655 W. Baltimore St, Balto, MD 21201</b>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Arteriosclerotic cardiovascular disease</b> IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO						26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined	
28a. DATE OF INJURY (Month, Day, Year)						28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED						28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>		29c. LICENSE NUMBER <b>O.C.M.E.</b>	
29d. DATE SIGNED (Month, Day, Year) <b>03 01 1991</b>						30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MARIO F. GOLLE JR., MD</b> <b>111 Penn Street, Baltimore Maryland 21201</b>		31. DATE FILED (Month, Day, Year) <b>MAR 5 1991</b>	
32. REGISTRAR'S SIGNATURE <i>[Signature]</i>									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 6 should be attached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05755

1. DECEDENT'S NAME (First, Middle, Last) <b>MARY LOUISE EGGELESTON</b>		2. DATE OF DEATH MONTH <b>3</b> DAY <b>3</b> YEAR <b>91</b>		3. TIME OF DEATH <b>6:30 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>218-22-7947</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>82</b> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <b>12-28-08</b>		8. BIRTHPLACE (State or Foreign Country) <b>PA.</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>BALTO. County Gen. Hosp.</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTO.</b>		9c. COUNTY OF DEATH	
10a. STATE <b>MD</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTO.</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>2540 Ashland Ave</b>		10f. ZIP CODE <b>21213</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Negro</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input checked="" type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <b>LUTHER Mearedith</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Victoria Fowlkes</b>			
19a. INFORMANT'S NAME (Type, Print) <b>Linda Smith</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2540 Ashland Ave BALTO. MD</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>BALTO. Cem.</b>		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Betts Funeral Home</b>		22. NAME AND ADDRESS OF FACILITY <b>1739 N. Caroline St</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. SEPSIS</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>PNEUMONIA + UTI</b> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>SEIZURES, COPD, CVA, SVT</b>					
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <b>C. Ravi MD</b>		29c. LICENSE NUMBER <b>D17333</b>		29d. DATE SIGNED (Month, Day, Year) <b>3-3-91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>C. Ravi MD, BCGH, RANDALL STOWN MD 21133</b>					
31. DATE FILED (Month, Day, Year) <b>MAR 05 1991</b>		32. REGISTRAR'S SIGNATURE <b>John [Signature]</b>			

100% COTTON FIBER  
MADE IN U.S.A.  
12/1/68

91 05756

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ELLIS HILDA B.</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>3</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>11:18 AM</b>	
4. SOCIAL SECURITY NUMBER <b>059-14-6512</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>71</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>1/11/20</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>SINAI HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>		9c. COUNTY OF DEATH	
10a. STATE <b>MARYLAND</b>				10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTIMORE CITY</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
10e. STREET AND NUMBER <b>3402 KESTON ROAD</b>				10f. ZIP CODE <b>21207</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>JOSEPH COMMODORE</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>BERTHA SMITH</b>			
19a. INFORMANT'S NAME (Type/Print) <b>JANICE A. ELLIS</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3402 KESTON ROAD: BALTIMORE, MD 21207</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>BALTIMORE NATIONAL</b>		DATE <b>3/8</b>		20c. LOCATION — City or Town, State <b>BALTIMORE, MARYLAND</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Leroy O. Dyett</i>				22. NAME AND ADDRESS OF FACILITY <b>LEROY O. DYETT &amp; SON FUNERAL HOME 4600 LIBERTY HEIGHTS AVENUE</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) <b>VENTRICULAR FIBRILLATION</b> DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ANOXIC BRAIN DEATH 2° to ANOXIC ENCEPHALOPATHY.</b>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Mark CUA MD</i>				29c. LICENSE NUMBER <b>D41022</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/3/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MARK CUA SINAI</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 05 1991</b>				32. REGISTRAR'S SIGNATURE <i>John Harrison</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 05757

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH  
REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Virgie ROWAN FRENCH</u>				2. DATE OF DEATH MONTH <u>2</u> DAY <u>28</u> YEAR <u>91</u>		3. TIME OF DEATH <u>10:35 PM</u>	
4. SOCIAL SECURITY NUMBER <u>141 18 4892 A</u>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>81</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>10-25-1909</u>	
8. BIRTHPLACE (State or Foreign Country) <u>Penna</u>				9a. FACILITY NAME (If not institution, give street and number) <u>at home: RD #1 Box 215 A</u>		9b. CITY, TOWN OR LOCATION OF DEATH <u>Goldsboro</u>	
9c. COUNTY OF DEATH <u>Caroline Co</u>				10a. STATE <u>MD</u>		10b. COUNTY <u>Caroline Co</u>	
10c. CITY, TOWN OR LOCATION <u>Goldsboro</u>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <u>R. D. #1 Box 215 A</u>	
10f. ZIP CODE <u>21636</u>				10g. CITIZEN OF WHAT COUNTRY? <u>USA</u>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <u>NO</u>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: <u>NO</u>			
14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>College (1-4 or 5+)</u>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <u>JOSEPH BURLEIGH ROWAN</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>LENA HUBBARD</u>			
19a. INFORMANT'S NAME (Type/Print)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Ronald Wade, Dir</u>				22. NAME AND ADDRESS OF FACILITY <u>STATE ANATOMY BOARD</u> <u>655 W. Baltimore St, Balto, MD 21201</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Urosepsis</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <u>Urosepsis</u> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>OBS, ↑BP, Breast CA</u>						Approximate Interval Between Onset and Death	
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>[Signature]</u>				29c. LICENSE NUMBER <u>D33294</u>		29d. DATE SIGNED (Month, Day, Year) <u>2/28/91</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>Rob Lappin MD PO Box 122 Goldsboro, Md. 21636</u>							
31. DATE FILED (Month, Day, Year) <u>MAR 5 1991</u>				32. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 1 must be signed by the hospital or attending physician. Page 2 must be signed by the funeral director and completely filled in by the funeral director prior to burial, cremation, or removal. Page 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Pages 1, 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Page 4 may be retained by the hospital or attending physician. Page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				91 05758			
CERTIFICATE OF DEATH				REG. NO.							
1. DECEDENT'S NAME (First, Middle, Last) <u>Theresa B. Gaskill</u>				2. DATE OF DEATH MONTH <u>2</u> DAY <u>27</u> YEAR <u>91</u>				3. TIME OF DEATH <u>7:30 PM</u>			
4. SOCIAL SECURITY NUMBER <u>314-34-3680</u>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>83</u> YRS.		IF UNDER 1 YEAR MONTHS <u>9</u> DAYS <u>10</u> HOURS <u>07</u> MIN.		7. DATE OF BIRTH (Month, Day, Year) <u>9 10 07</u>		8. BIRTHPLACE (State or Foreign Country) <u>Maryland</u>	
9a. FACILITY NAME (If not institution, give street and number) <u>Anne Arundel Medical Center</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>Annapolis</u>				9c. COUNTY OF DEATH <u>Anne Arundel Co</u>			
10a. STATE <u>MD</u>		10b. COUNTY <u>Baltimore Co</u>		10c. CITY, TOWN OR LOCATION <u>Dundalk</u>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER <u>13 Dundalk Avenue</u>				10f. ZIP CODE <u>21222</u>				10g. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <u>NO</u>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: <u>NO</u>		14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>Elementary</u> College (14 or 5+) <u>College (14 or 5+)</u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Retired</u>		16b. KIND OF BUSINESS/INDUSTRY <u>Tavern Owner</u>							
17. FATHER'S NAME (First, Middle, Last) <u>STANISLAUS KOLODZIEJ</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>THERESA PZCYWIESKI</u>							
19a. INFORMANT'S NAME (Type/Print) <u>Dr. Richard Morris Son</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>700 Seth Court Towson, MD 21204</u>							
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)		20c. LOCATION — City or Town, State							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Ronald Wade, Dir</u> <u>3/4/91</u>				22. NAME AND ADDRESS OF FACILITY <u>State Anatomy Board</u> <u>655 W. Baltimore St, Balto, MD 21201</u>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Head and neck Cancer</u> DUE TO (OR AS A CONSEQUENCE OF): <u>Amnesia</u> Sequitely that conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <u>Gastrointestinal bleeding</u> <u>Head and neck Cancer</u>								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		25. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <u>Mark G. Getka MD.</u>				29c. LICENSE NUMBER <u>D 28303</u>		29d. DATE SIGNED (Month, Day, Year) <u>2/28/91</u>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>MARC A. GETKA</u>											
31. DATE FILED (Month, Day, Year) <u>MAR 25/1991</u>				32. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>							



91-1152-510

91 05759

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Sullie W. Green				2. DATE OF DEATH MONTH DAY YEAR 03 01 1991		3. TIME OF DEATH 2:15 P M	
4. SOCIAL SECURITY NUMBER 218-28-3112		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 58 YRS.		7. DATE OF BIRTH (Month, Day, Year) 8-29-32	
8. BIRTHPLACE (State or Foreign Country) N.C.				9a. FACILITY NAME (If not institution, give street and number) Union Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City	
9c. COUNTY OF DEATH				10a. STATE MD		10b. COUNTY BALTIMORE, CITY	
10c. CITY, TOWN OR LOCATION				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 2306 E. LAFAYETTE	
10f. ZIP CODE 21213				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6th College (1-4 or 5+) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SANITATION DEPT.		16b. KIND OF BUSINESS/INDUSTRY BALTIMORE CITY	
17. FATHER'S NAME (First, Middle, Last) WILLIAM GREEN				18. MOTHER'S NAME (First, Middle, Maiden Surname) INEZ REED			
19a. INFORMANT'S NAME (Type/Print) VIRGINIA GREEN ANDERSON				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2306 E. LAFAYETTE/BALTIMORE, MD. 21213			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, or other place) BALTIMORE CEMETERY		20c. LOCATION — City or Town, State BALTIMORE, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Bladine Wanner				22. NAME AND ADDRESS OF FACILITY WM.C. MARCH F.H. 1101 E. NORTH AVE			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Atherosclerotic cardiovascular disease Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER A. M. Dixon				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) 03 02 1991	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) A. M. Dixon 111 Penn Street, Baltimore Maryland, 21201							
31. DATE FILED (Month, Day, Year) MAR 05 1991				32. REGISTRAR'S SIGNATURE John Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

112 2431093

EX-111

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				91 05760	
1 - FOR STATE REGISTRAR				CERTIFICATE OF DEATH	
1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH (Month, Day, Year)	
ESTELLA M. GREENWALD				MARCH 2 1991	
4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. last birthday)	7. DATE OF BIRTH (Month, Day, Year)	
216-48-0872		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	92 YRS.	SEPT. 3 1898	
9a. FACILITY NAME (If not institution, give street and number)				9b. CITY, TOWN OR LOCATION OF DEATH	
HOMEWOOD HOSPITAL				BALTIMORE	
10a. STATE				10b. COUNTY	
MD.				-----	
10c. CITY, TOWN OR LOCATION				10d. INSIDE CITY LIMITS?	
BALTIMORE				<input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER				10f. ZIP CODE	
3232 BELAIR ROAD				21213	
10g. CITIZEN OF WHAT COUNTRY?				11. MARITAL STATUS	
U.S.A.				1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married	
				3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	
IF YES, GIVE WAR OR DATES				1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify:				WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	
Elementary/Secondary (0-12) N/A				College (1-4 or 5+) N/A	
16b. KIND OF BUSINESS/INDUSTRY				OWN HOME	
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)	
JOSEPH MAENNER				MARGARET BUTT	
19a. INFORMANT'S NAME (Type/Print)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
MARIE SIEWIERSKI (DGHTER)				3326 RAMONA AVENUE, BALTIMORE, MD. 21213	
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	
				GARDENS OF FAITH CEMETERY	
20c. LOCATION — City or Town, State				BALTO. MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE				22. NAME AND ADDRESS OF FACILITY	
<i>[Signature]</i>				SCHIMUNEK FUNERAL HOME INC. 3331 Brehms Lane, Baltimore, Md. 21213	
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) →					
a. <i>Hyperosmolar Coma</i>					
b. <i>HYPOTENSION</i>					
c. <i>DEHYDRATION</i>					
d. <i>SEPTICEMIA</i>					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
<i>D/M</i>				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
<i>Senile Dementia</i>					
<i>CARDIAC ARRHYTHMIA</i>					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one)	
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA				OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)	
				28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER	
				29c. LICENSE NUMBER	
<i>[Signature]</i>				29d. DATE SIGNED (Month, Day, Year)	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)				31. DATE FILED (Month, Day, Year)	
AMBACHEW WORETA MD HOMEWOOD HOSPITAL				MAR 05 1991	
32. REGISTRAR'S SIGNATURE				33. REGISTRAR'S SIGNATURE	
<i>[Signature]</i>				<i>[Signature]</i>	



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				REG. NO.		91 05761					
CERTIFICATE OF DEATH								2:10 AM					
1. DECEDENT'S NAME (First, Middle, Last) <b>BENJAMIN GUMNIT (BENJAMIN GUMNIT)</b>				2. DATE OF DEATH MONTH <b>3</b> - DAY <b>1</b> - YEAR <b>91</b>		3. TIME OF DEATH <b>0210 M</b>							
4. SOCIAL SECURITY NUMBER <b>216-32-8755</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>85</b> YRS.	IF UNDER 1 YEAR MONTHS <b>3</b> DAYS <b>1</b>	IF UNDER 24 HRS. HOURS <b>1</b> MIN. <b>0</b>	7. DATE OF BIRTH (Month, Day, Year) <b>7/14/1905</b>		8. BIRTHPLACE (State or Foreign Country) <b>RUSSIA</b>					
9a. FACILITY NAME (If not institution, give street and number) <b>BALTIMORE COUNTY GENERAL HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>RANDALLSTOWN</b>		9c. COUNTY OF DEATH <b>BALTIMORE</b>							
RESIDENCE OF DECEDENT													
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>BALTIMORE</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER <b>405 SOUTH RD.</b>				10f. ZIP CODE <b>21208</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>12</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>GROCCER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>FOOD</b>									
17. FATHER'S NAME (First, Middle, Last) <b>NATHAN GUMNITZKY</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>KATE UNKNOWN</b>									
19a. INFORMANT'S NAME (Type/Print) <b>MR. STANLEY GUMNIT</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>405 SOUTH RD. BALTIMORE, MD 21208</b>									
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>SHAAREI TION</b>		20c. LOCATION — City or Town, State <b>3/3/91</b>		20d. LOCATION — City or Town, State <b>ROSEDALE, MD</b>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>SOL LEVINSON &amp; BROS., INC.</b> <b>6010 REISTERSTOWN RD. BALTIMORE, MD 21215</b>									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>SEPSIS</b> <b>DUE TO (OR AS A CONSEQUENCE OF):</b> <b>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> <b>a. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>b. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>c. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>d. DUE TO (OR AS A CONSEQUENCE OF):</b>								Approximate Interval Between Onset and Death					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>PACER, DEMENTIA, ALZHEIMER</b> <b>PARKINSON'S.</b>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD		29c. LICENSE NUMBER <b>D37333</b>		29d. DATE SIGNED (Month, Day, Year) <b>3.1.91</b>							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>C. RAVI, BCGH, RANDALLSTOWN, MD. 21133.</b>													
31. DATE FILED (Month, Day, Year) <b>MAR 05 1991</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>									





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05762

1. DECEDENT'S NAME (First, Middle, Last) <b>KATHERINE GIBSON</b>				2. DATE OF DEATH MONTH <b>2</b> DAY <b>26</b> YEAR <b>91</b>		3. TIME OF DEATH <b>0250 A M</b>				
4. SOCIAL SECURITY NUMBER <b>577-30-5167</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>88</b> YRS.		7. DATE OF BIRTH <b>3/24/02</b>		8. BIRTHPLACE (State or Foreign Country) <b>DC</b>		
9a. FACILITY NAME (If not institution, give street and number) <b>Washington Adventist Hosp</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Takoma Park, Md</b>			9c. COUNTY OF DEATH <b>PG</b>			
10a. STATE <b>DC</b>				10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Washington</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
10e. STREET AND NUMBER <b>728 9th St SE</b>				10f. ZIP CODE <b>20003</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. <b>Black</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 Yrs</b> College (1-4 or 5+) <b>None</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>			16b. KIND OF BUSINESS/INDUSTRY					
17. FATHER'S NAME (First, Middle, Last) <b>Isaac Scott</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname)						
19a. INFORMANT'S NAME (Type/Print) <b>Ellsworth F Gibson</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Same as 10a,b,c,e,d,&amp;f</b>						
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Lincoln Memorial</b>			20c. LOCATION — City or Town, State <b>Suitland, Md</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Wagel</b>				22. NAME AND ADDRESS OF FACILITY <b>John T Rhines Co., Inc 3015 12th ST NE, DC 20017</b>						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>cardiovascular failure</b> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <b>chronic coronary artery failure</b> b. <b>hypertension</b> c. <b>atherosclerosis</b> d. <b>myocardial infarction</b>							Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>chronic kidney disease</b> <b>diabetes mellitus</b> <b>stroke</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <b>John T Rhines</b>		29c. LICENSE NUMBER <b>201499</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/26/91</b>		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)										
31. DATE FILED (Month, Day, Year) <b>MAR 5 1991</b>				32. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>						



REG. NO.

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05764

1. DECEDENT'S NAME (First, Middle, Last) ELNA BEVERLY GRIFFIN				2. DATE OF DEATH MONTH DAY YEAR MARCH 1 1991		3. TIME OF DEATH 1030 M				
4. SOCIAL SECURITY NUMBER 552-22-0910		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 68 YRS.		7. DATE OF BIRTH (Month, Day, Year) 6/25/22		8. BIRTHPLACE (State or Foreign Country) California		
9a. FACILITY NAME (If not Institution, give street and number) PENINSULA GENERAL HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY			9c. COUNTY OF DEATH WICOMICO			
10a. STATE Md.			10b. COUNTY Worcester		10c. CITY, TOWN OR LOCATION Berlin			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER P. O. Box 556				10f. ZIP CODE 21811		10g. CITIZEN OF WHAT COUNTRY? USA				
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 yrs. College (1-4 or 5+) College (1-4 or 5+)			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Librarian			16b. KIND OF BUSINESS/INDUSTRY Media Specialist				
17. FATHER'S NAME (First, Middle, Last) Paul Birkholm				18. MOTHER'S NAME (First, Middle, Maiden Surname) Rhoda Pasquel						
19a. INFORMANT'S NAME (Type/Print) William James Griffin				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P. O. Box 556 Berlin, Md. 21811						
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Evergreen Cemetery			20c. LOCATION — City or Town, State Berlin, Md.					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dr. Kirk Burbage				22. NAME AND ADDRESS OF FACILITY Burbage Funeral Home 108 Williams St. Berlin, Md. 21811						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiac arrest DUE TO (OR AS A CONSEQUENCE OF): b. Atherosclerotic cardiovascular disease DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Severe peripheral vascular disease Congestive heart failure							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER Clayton L. Raab M.D.				29c. LICENSE NUMBER D19289		29d. DATE SIGNED (Month, Day, Year) 3/1/91				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 560 Riverside Dr. Salisbury Md. Clayton L. Raab M.D.										
31. DATE FILED (Month, Day, Year) MAR 05 1991				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall						



91 05765

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) John R. Hand				2. DATE OF DEATH MONTH DAY YEAR 3/4/91		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER 213-10-8226		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		8. AGE (In yrs. last birthday) 79 YRS.		7. DATE OF BIRTH (Month, Day, Year) 12/26/11	
9a. FACILITY NAME (If not institution, give street and number) 2202 Southland Road		9b. CITY, TOWN OR LOCATION OF DEATH Woodlawn		9c. COUNTY OF DEATH Baltimore			
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Woodlawn		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 2202 Southland Road				10f. ZIP CODE 21207		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 Years		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Electrical Engineer		16b. KIND OF BUSINESS/INDUSTRY General Elevator Co.			
17. FATHER'S NAME (First, Middle, Last) John Scott Hand				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Elizabeth Robinson			
19a. INFORMANT'S NAME (Type/Print) Mrs. Nancy H. Halgren				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 737 First St. Culpeper, VA 22701			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Lorraine Park Cemetery 3/6/91		20c. LOCATION — City or Town, State Woodlawn, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE James B. Covey				22. NAME AND ADDRESS OF FACILITY Loring Byers Funeral Home 8728 Liberty Road Randallstown, MD 21133			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Metastatic colonic adenocarcinoma 6 years Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Nomicide 4 <input type="checkbox"/>		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Marshall A. Levine				29c. LICENSE NUMBER D17873		29d. DATE SIGNED (Month, Day, Year) 3/4/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Marshall A. Levine, 4000 Old Court Rd, Baltimore, MD 21208							
31. DATE FILED (Month, Day, Year) MAR 05 1991				32. REGISTRAR'S SIGNATURE John Davidson			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.







91 05766

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Norma E. Heline</b>				2. DATE OF DEATH MONTH DAY YEAR <b>3 - 5 - 91</b>		3. TIME OF DEATH <b>1:40 A M</b>	
4. SOCIAL SECURITY NUMBER <b>219-36-0511</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>89</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>12-17-01</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Baltimore County General Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Randallstown</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Randallstown</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>3605 Stoneybrook Road</b>				10f. ZIP CODE <b>21133</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Caucasian</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8th Grade</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>John Henry Philburn</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Margaret Sommers</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Norma Blocher</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3605 Stoneybrook Rd. Randallstown, MD 21133</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Carroll Cremation Company</b>		20c. LOCATION — City or Town, State <b>Hampstead, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Joseph W. Kellner</b>				22. NAME AND ADDRESS OF FACILITY <b>Loring Byers Funeral Directors, INC. 8728 Liberty Rd. Randallstown, MD 21133-4784</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF):							
b. <b>Cerebral Vascular Accident</b> DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>[Signature]</b>				29c. LICENSE NUMBER <b>037949</b>		29d. DATE SIGNED (Month, Day, Year) <b>3-5-91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>5401 Oldcourt Road, Randallstown, Maryland, 21133</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 05 1991</b>				32. REGISTRAR'S SIGNATURE <b>Johanna Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 05767

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) Howard Head				2. DATE OF DEATH MONTH 03 DAY 03 YEAR 91		3. TIME OF DEATH 9:26p M	
4. SOCIAL SECURITY NUMBER 179-05-3373		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 76 YRS.	7. DATE OF BIRTH (Month, Day, Year) July 31, 1914		8. BIRTHPLACE (State or Foreign Country) Pennsylvania	
9a. FACILITY NAME (If not institution, give street and number) JOHNS HOPKINS HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH BALTIMORE	
10a. STATE Maryland		10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore City		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 21 Blythewood Rd.				10f. ZIP CODE 21210		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (14 or 5+) 4 Years		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Inventor		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) Dr. Joseph Head				18. MOTHER'S NAME (First, Middle, Maiden Surname) Annie Wilkensen			
19a. INFORMANT'S NAME (Type/Print) Martha Fritzlen Head				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21 Blythewood Rd. Baltimore, Md. 21210			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) State Anatomy Board		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE James F. Burnside, Jr.				22. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Baltimore, Md. 21212			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → Overwhelming Sepsis a. DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Complications of cardiac bypass surgery. b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death 2 days. 2 wks	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic renal failure.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER K. G. Surgery Resident		29c. LICENSE NUMBER D39104		29d. DATE SIGNED (Month, Day, Year) 3/3/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Johns Hopkins Hospital, Balto., MD 21205							
31. DATE FILED (Month, Day, Year) MAR 05 1991		32. REGISTRAR'S SIGNATURE Julia Davidson-Randall					

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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91 05768

1 FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>HARRY HIGHKIN</b>				2. DATE OF DEATH MONTH <b>2</b> DAY <b>27</b> YEAR <b>91</b>				3. TIME OF DEATH <b>1245P</b>					
4. SOCIAL SECURITY NUMBER <b>212-03-7919</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>88</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>		7. DATE OF BIRTH (Month, Day, Year) <b>SEPT. 1, 1902</b>		8. BIRTHPLACE (State or Foreign Country) <b>RUSSIA</b>		
9a. FACILITY NAME (If not institution, give street and number) <b>PIKESVILLE NURSING HOME</b>					9b. CITY, TOWN OR LOCATION OF DEATH <b>PIKESVILLE</b>				9c. COUNTY OF DEATH <b>BALTIMORE</b>				
10a. STATE <b>MARYLAND</b>				10b. COUNTY <b>BALTIMORE</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER <b>2305 GERARD CT.</b>					10f. ZIP CODE <b>21209</b>			10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify <b>WHITE</b>				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+) <b>0</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>DENTAL TECH</b>				16b. KIND OF BUSINESS/INDUSTRY <b>DENTISTRY</b>					
17. FATHER'S NAME (First, Middle, Last) <b>SAMUEL HIGHKIN</b>					18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MARSHA UNKNOWN</b>								
19a. INFORMANT'S NAME (Type/Print) <b>MRS. BERTHA HIGHKIN</b>					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2305 GERARD CT. BALTIMORE, MD 21209</b>								
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>BETH ISAAC ADATH ISRAEL 3/1/91</b>			DATE <b>3/1/91</b>		20c. LOCATION — City or Town, State <b>BALTIMORE, MD</b>				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Ellen See Levinson</b>					22. NAME AND ADDRESS OF FACILITY <b>SOL LEVINSON &amp; BROS., INC. 6010 REISTERSTOWN RD. BALTIMORE, MD 21215</b>								
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) →  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. <b>respiratory failure</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Heart Coronary insufficiency</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>Thromboembolic purpura</b> DUE TO (OR AS A CONSEQUENCE OF): d. <b>Dementia</b>										Approximate interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <b>David J. Penn</b>				29c. LICENSE NUMBER <b>02998</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/27/91</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DAVID J. PENN, M.D. 3635 Old Court Rd 21208</b>													
31. DATE FILED (Month, Day, Year) <b>MAR 05 1991</b>				32. REGISTRAR'S SIGNATURE <b>J. Davidson-Randall</b>									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOX B1/V115

**STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH**

91 05769

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Beulah Vistie HARRISON</b>		2. DATE OF DEATH MONTH <b>3</b> DAY <b>1</b> YEAR <b>91</b>		3. TIME OF DEATH <b>12 P M</b>	
4. SOCIAL SECURITY NUMBER <b>579-42-5602</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>66</b> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <b>9-7-24</b>		8. BIRTHPLACE (State or Foreign Country) <b>Va</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>6030 SARGENT ROAD apt 3207</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>HYATTSVILLE</b>		9c. COUNTY OF DEATH <b>PRINCE GEORGE</b>	
RESIDENCE OF DECEDENT					
10a. STATE <b>MD</b>		10b. COUNTY <b>PRINCE GEORGE</b>		10c. CITY, TOWN OR LOCATION <b>HYATTSVILLE</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
10e. STREET AND NUMBER <b>6030 SARGENT ROAD apt 3207</b>		10f. ZIP CODE <b>20782</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7 Yrs</b> College (1-4 or 5+) <b>None</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <b>Louis Young</b>			18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Ruth Gray</b>		
19a. INFORMANT'S NAME (Type/Print) <b>Eugene W Harrison</b>			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Same as 10a,b,c,d,e,&amp;f</b>		
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		20c. LOCATION — City or Town, State <b>Norman, Va</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Hazel Plummer</b>			22. NAME AND ADDRESS OF FACILITY <b>John T Rhines Co., Inc 3030 12th St NE, DC 20017</b>		
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Myocardial Infarction</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Arteriosclerosis Cardiovascular Disease</b> DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):					Approximate Interval Between Onset and Death <b>minutes</b>  <b>years</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DIABETES MELLITUS, HYPERTENSION</b>					24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
					24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>N/A</b>		28b. TIME OF INJURY <b>M</b>	
		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Deputy Medical Examiner</b>		29c. LICENSE NUMBER <b>201852</b>		29d. DATE SIGNED (Month, Day, Year) <b>3-1-91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>PAUL A. DEVORE M.D. 4203 QUEENSBURY RD Hyattsville MD 20781</b>					
31. DATE FILED (Month, Day, Year) <b>MAR 5 1991</b>		32. REGISTRAR'S SIGNATURE <b>Jenia Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020  
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05770

1. DECEDENT'S NAME (First, Middle, Last) JAMES P HOLDEN 111		2. DATE OF DEATH 05 02 1991		3. TIME OF DEATH 2:30 P M	
4. SOCIAL SECURITY NUMBER 216-58-4245		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 37 YRS.	
7. DATE OF BIRTH (Month, Day, Year) Sept. 30, 1953		8. BIRTHPLACE (State or Foreign Country) MD.			
9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH BALITMORE CITY		9c. COUNTY OF DEATH BALTIMORE CITY	
10a. STATE Md.		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Essex	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 315 Margaret Ave.		10f. ZIP CODE 21221	
10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS X <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2yrs.		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) unemployed		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) James P. Holden Jr.		18. MOTHER'S NAME (First, Middle, Maiden Surname) Shirley Unkelbach			
19a. INFORMANT'S NAME (Type/Print) James Holden Jr.		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 315 Margaret Ave. Baltimore Md. 21221			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory Inc.		20c. LOCATION — City or Town, State Baltimore Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Connelly Funeral Home		22. NAME AND ADDRESS OF FACILITY ConnellyFuneralHome300MAceAve.21221			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Apnea DUE TO (OR AS A CONSEQUENCE OF): b. pulmonary edema DUE TO (OR AS A CONSEQUENCE OF): c. MAI Mycobacterium Avium Intracellulare DUE TO (OR AS A CONSEQUENCE OF): d. AIDS Acquired Immune Deficiency Syndrome		Approximate Interval Between Onset and Death 2 minutes 5 days 1 year 7 years			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER J. A. Sami, MD		29c. LICENSE NUMBER E9920	
29d. DATE SIGNED (Month, Day, Year) 3/2/91		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Johns Hopkins Hosp 600 N. Wolfe Street Baltimore, MD 21205			
31. DATE FILED (Month, Day, Year) 3/2/91		32. REGISTRAR'S SIGNATURE John A. Sami			

THE UNIVERSITY OF CHICAGO

20% COTTON

ITEMS:10f,19b per FH  
G-673 3/7/91 cm #1

91 05771

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>BARBARA HOCKETT</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>1</b> YEAR <b>91</b>		3. TIME OF DEATH <b>4:21</b> P M	
4. SOCIAL SECURITY NUMBER		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>49</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>9-2-41</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Balto. County General Hosp.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH <b>BALTIMORE</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MD.</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>7905 Montwood Road</b>				10f. ZIP CODE <b>21201 21207</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>College (1-4 or 5+)</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Social Security</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Government</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Charlie Wynn</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Allen</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Timothy Hockett</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7905 Montwood Road Balto., MD. 21201 21207</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Balto., National Cem.</b>		20c. LOCATION — City or Town, State <b>Balto., MD.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Doretha Hector #281</b>				22. NAME AND ADDRESS OF FACILITY <b>E.L. Phillips F/H 1721-27 N. Monroe Balto., MD. 21217</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Arteriosclerotic Cardiovascular Disease 1 year</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DIABETES MELLITUS</b>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>E.P. Williams M.D.</b>				29c. LICENSE NUMBER <b>01171</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/1/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>E.P. Williams M.D. 405 Frederick Ave. - Catonsville, Md.</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 05 1991</b>				32. REGISTRAR'S SIGNATURE <b>John R. ...</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 05772

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Jerome Harcum				2. DATE OF DEATH MONTH 2 DAY 27 YEAR 91		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER 216-34-3793		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 51 YRS.		7. DATE OF BIRTH (Month, Day, Year) 8 16 39	
8. BIRTHPLACE (State or Foreign Country) Maryland		9a. FACILITY NAME (If not institution, give street and number) 2140 Vine Street				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore	
9c. COUNTY OF DEATH				10a. STATE MD.			
10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 2140 Vine Street				10f. ZIP CODE 21223		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Disabled		16b. KIND OF BUSINESS/INDUSTRY Giant Supre Market			
17. FATHER'S NAME (First, Middle, Last) Irvin Harcum				18. MOTHER'S NAME (First, Middle, Maiden Surname) Nannie Bowler			
19a. INFORMANT'S NAME (Type/Print) Evelyn Stevenson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2140 Vine Street Balto., MD. 21223			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Arbutus Mem. Park 3-4-91		20c. LOCATION — City or Town, State Balto., MD.		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dorothy Hector #281				22. NAME AND ADDRESS OF FACILITY E.L. Phillips F/H 1721-27 N. Monroe Balto., MD. 21217			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → METASTATIC LUNG CANCER DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER Attending Physician				29c. LICENSE NUMBER D29071		29d. DATE SIGNED (Month, Day, Year) 3.4.91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) R. KRISHNAN, MD 821 N. EUTAW ST. #308 BALTIMORE MD 21201							
31. DATE FILED (Month, Day, Year) MAR 05 1991				32. REGISTRAR'S SIGNATURE John Davidson-Randell			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 must be retained by the hospital or attending physician. Page 6 must be retained by the funeral director. Page 7 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05773

1. DECEDENT'S NAME (First, Middle, Last) <b>LEONARD JONES</b>				2. DATE OF DEATH MONTH <b>FEB</b> DAY <b>28</b> YEAR <b>91</b>				3. TIME OF DEATH <b>5:35 PM</b>	
4. SOCIAL SECURITY NUMBER <b>579-26-0203</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>89</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>SEPT 6, 1901</b>		8. BIRTHPLACE (State or Foreign Country) <b>WASHINGTON D.C.</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>107 69th Street</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Seat Pleasant</b>				9c. COUNTY OF DEATH <b>Prince George Co</b>	
10a. STATE <b>MD</b>		10b. COUNTY <b>Prince George co</b>		10c. CITY, TOWN OR LOCATION <b>Seat Pleasant</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>107 69th Street</b>				10f. ZIP CODE <b>20743</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY					
17. FATHER'S NAME (First, Middle, Last)				16. MOTHER'S NAME (First, Middle, Maiden Surname)					
19a. INFORMANT'S NAME (Type/Print) <b>Esther Settles Friend</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>107 69th St, Seat Pleasant, MD 20743</b>					
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>In state</b>		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)				20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Ronald Wade, Dir</b> <b>3/1/91</b>				22. NAME AND ADDRESS OF FACILITY <b>STATE ANATOMY BOARD</b> <b>655 West Baltimore St, Balto, MD 21201</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Anemia</b>  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. <b>Arteriosclerotic Cardiovascular Disease</b> b. c. d.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Alfred W. M.D.</b>				29c. LICENSE NUMBER <b>212879</b>				29d. DATE SIGNED (Month, Day, Year) <b>FEB 28, 1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>10701 TRAPTON DR., LARGO, MD 20772</b>									
31. DATE FILED (Month, Day, Year) <b>MAR 5 1991</b>				32. REGISTRAR'S SIGNATURE <b>Jana Davidson</b>					





91 05774

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MILDRED B JOHNSON</b>				2. DATE OF DEATH MONTH <b>2</b> DAY <b>28</b> YEAR <b>91</b>		3. TIME OF DEATH <b>11 30 P M</b>	
4. SOCIAL SECURITY NUMBER <b>219-18-8270</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>66</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>10/01/24</b>	
8. BIRTHPLACE (State or Foreign Country) <b>MD</b>				9a. FACILITY NAME (If not institution, give street and number) <b>SINAI HOSP. OF BALTIMORE</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>	
9c. COUNTY OF DEATH				10a. STATE <b>MD</b>			
10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER <b>806 Mt. HOLLY STREET</b>				10f. ZIP CODE <b>21229</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (14 or 5+) <input checked="" type="checkbox"/> <b>College - Master</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <b>Walter Bryant</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Alberta Anthony</b>			
19a. INFORMANT'S NAME (Type/Print) <b>John H. Bryant</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>806 Mt Holly St Balt, Md 21229</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Garrison Forest 3591</b>		20c. LOCATION — City or Town, State <b>Cwings Mills, MD</b>		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Sola March</b>				22. NAME AND ADDRESS OF FACILITY <b>March F. H. West 4300 Westbrook Ave</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>r/o Basilar Occlusion</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Benjamin P. Felipe INTERN</b>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>2/28/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>BENJAMIN FELIPE SINAI HOSP. OF BALTIMORE</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 05 1991</b>		32. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 05775

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Mildred J. Jones</i>				2. DATE OF DEATH MONTH <i>2</i> DAY <i>28</i> YEAR <i>'91</i>		3. TIME OF DEATH <i>11 06 A M</i>	
4. SOCIAL SECURITY NUMBER <i>216-50-2492</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (in yrs. last birthday) <i>41</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>3/12/49</i>	
8. BIRTHPLACE (State or Foreign Country) <i>MARYLAND</i>				9a. FACILITY NAME (If not institution, give street and number) <i>UNIVERSITY HOSPITAL</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>BALTIMORE CITY</i>	
9c. COUNTY OF DEATH				10a. STATE <i>MARYLAND</i>		10b. COUNTY	
10c. CITY, TOWN OR LOCATION <i>BALTIMORE CITY</i>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <i>1809 FULTON AVENUE</i>	
10f. ZIP CODE <i>21217</i>				10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>BLACK</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <i>JAMES KENDRICK</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>VIRGIE KENDRICK</i>			
19a. INFORMANT'S NAME (Type/Print) <i>JAMES KENDRICK</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1809 N. FULTON AVENUE: BALTIMORE, MD 21217</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <i>WESTERN STAR CEMETERY</i>		20c. LOCATION — City or Town, State <i>CATONSVILLE, MD.</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Leroy O. Dyett</i>				22. NAME AND ADDRESS OF FACILITY <i>LEROY O. DYETT &amp; SON FUNERAL HOME 4600 LIBERTY HEIGHTS AVENUE</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) <i>Respiratory Arrest</i> DUE TO (OR AS A CONSEQUENCE OF): <i>Probable Trachea disruption with Subcutaneous emphysema</i> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Ruth Herring MD resident</i>			
29c. LICENSE NUMBER				29d. DATE SIGNED (Month, Day, Year) <i>2/28/91</i>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>22 S. Greene Street Baltimore MD 21201</i>							
31. DATE FILED (Month, Day, Year) <i>MAR 05 1991</i>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1142  
FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05776

1. DECEDENT'S NAME (First, Middle, Last) <b>CHARLES KANLEY</b>		2. DATE OF DEATH MONTH <b>03</b> DAY <b>01</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>3:55 A</b> M	
4. SOCIAL SECURITY NUMBER <b>212-01-6451</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>78</b> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <b>3-17-12</b>		8. BIRTHPLACE (State or Foreign Country) <b>MD</b>		9. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>	
10a. STATE <b>MD</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Rosedale</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>1007 Chesaco Ave.</b>		10f. ZIP CODE <b>21237</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>1</b>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Armed Stool</b>		16b. KIND OF BUSINESS/INDUSTRY		17. FATHER'S NAME (First, Middle, Last) <b>Charles h. Kanley</b>	
18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary A. Sudbrook</b>		19a. INFORMANT'S NAME (Type/Print) <b>Gloria Baile</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2300 Leeward Dr., Westminster, MD 21157</b>	
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Gardens of Faith 3/4/91</b>		20c. LOCATION — City or Town, State <b>Baltimore, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Denise S. Kelly</b>		22. NAME AND ADDRESS OF FACILITY <b>Cvach/Rosedale Funeral Home 1211 Chesaco Ave.</b>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. CONTACT GUNSHOT WOUND OF HEAD</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined	
28a. DATE OF INJURY (Month, Day, Year) <b>02 31 1991</b>		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED <b>Shot self</b>		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>HOME</b>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>1007 Chesaco Ave., 21237 B.CO.</b>	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>Mario F. Golle, Jr.</b>		29c. LICENSE NUMBER <b>OCME</b>	
29d. DATE SIGNED (Month, Day, Year) <b>03 01 1991</b>		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print) <b>Mario F. Golle, Jr., M.D., A/MED. EX., 111 PENN STREET BALTIMORE, MARYLAND 21201</b>		31. DATE FILED (Month, Day, Year) <b>MAR 05 1991</b>	
32. REGISTRAR'S SIGNATURE <b>Gina Davidson-Randall</b>					

1963

PLANT BOMB

91 05777

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) George J. Kispert, Sr.				2. DATE OF DEATH MONTH DAY YEAR 03-01-91		3. TIME OF DEATH 9:11 AM	
4. SOCIAL SECURITY NUMBER 218-05-1938		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 76 YRS.		7. DATE OF BIRTH (Month, Day, Year) 01-01-15	
8. BIRTHPLACE (State or Foreign Country) Baltimore				9a. FACILITY NAME (If not institution, give street and number) Stella Maris		9b. CITY, TOWN OR LOCATION OF DEATH Towson	
9c. COUNTY OF DEATH Baltimore				10a. STATE Maryland		10b. COUNTY Baltimore	
10c. CITY, TOWN OR LOCATION Towson				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 517 Goucher Blvd.	
10f. ZIP CODE 21204		10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Caucasian		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Engineer	
16b. KIND OF BUSINESS/INDUSTRY Exxon Oil		17. FATHER'S NAME (First, Middle, Last) Anthony Kispert		18. MOTHER'S NAME (First, Middle, Maiden Surname) Meisel		19a. INFORMANT'S NAME (Type/Print) George J. Kispert, Jr.	
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3305 Summit Ave. Carney, Md 21234		20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Dulaney Valley Mem. Grdns.		20c. LOCATION — City or Town, State Timonium, Md	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Martin D. Lawson		22. NAME AND ADDRESS OF FACILITY Lemmon-Mitchell-Wiedefeld Inc. 10 W. Padonia Road timonium, Md 21093		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): Adv. ASCVD Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Dementia DUE TO (OR AS A CONSEQUENCE OF):		Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> POA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)	
28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
28f. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER		29c. LICENSE NUMBER 154506	
29d. DATE SIGNED (Month, Day, Year)		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Eddie Nakhuda 2300 Dulaney Valley RD. Towson, Maryland 21204		31. DATE FILED (Month, Day, Year) MAR 05 1991		32. REGISTRAR'S SIGNATURE Jisha Davidson-Randall	

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				CERTIFICATE OF DEATH				REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last) Ella Lewis						2. DATE OF DEATH MONTH DAY YEAR March 1, 1991				3. TIME OF DEATH 4:10 A M					
4. SOCIAL SECURITY NUMBER 579-56-3698		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 55 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH Month Day Year 12-23-1935		8. BIRTHPLACE (State or Foreign Country) South Carolina			
9a. FACILITY NAME (If not institution, give street and number) Maryland General Hospital						9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City				9c. COUNTY OF DEATH					
RESIDENCE OF DECEDENT															
10a. STATE MD		10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER 720 Newington Avenue						10f. ZIP CODE 21217				10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: Black							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)      College (1-4 or 5 +)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Disability				16b. KIND OF BUSINESS/INDUSTRY							
17. FATHER'S NAME (First, Middle, Last) James Anthony, Sr.						18. MOTHER'S NAME (First, Middle, Maiden Surname) Annie Bell Smalls									
19a. INFORMANT'S NAME (Type/Print) Ms. Patricia Anthony						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 720 Newington Avenue, Balto., MD 21217									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematorium, or place) Western Star Cem. Balto. Co. Md.				20c. LOCATION — City or Town, State Balto. Co. Md.							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Joseph L. Russ				22. NAME AND ADDRESS OF FACILITY Joseph L. Russ Funeral Home 2222 W. NORTH AVE. BALTO MD 21216											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic Adenocarcinoma of Stomach DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.										Approximate Interval Between Onset and Death 22 mos					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Malnutrition Chronic Bowel Obstruction										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER [Signature] Firearm						29c. LICENSE NUMBER D 3042		29d. DATE SIGNED (Month, Day, Year) 3/1/91							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 301 S. Paul Place #204 Balto MD 21202															
31. DATE FILED (Month, Day, Year) MAR 05 1991				32. REGISTRAR'S SIGNATURE John Davidson-Randall											



ITEM:1 per FH  
G-673 3/7/91 cm

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05779

1. DECEDENT'S NAME (First, Middle, Last) Hester M. L. Long				2. DATE OF DEATH March 1, 1991		3. TIME OF DEATH 12:12pm					
4. SOCIAL SECURITY NUMBER 578-22-6931		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 84 YRS.		7. DATE OF BIRTH (Month, Day, Year) 1-20-1907		8. BIRTHPLACE (State or Foreign Country) N. C.			
9a. FACILITY NAME (If not institution, give street and number) Maryland General Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore			9c. COUNTY OF DEATH				
10a. STATE D. C.				10b. COUNTY		10c. CITY, TOWN OR LOCATION Washington		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 5023 Illinois Avenue				10f. ZIP CODE 20011		10g. CITIZEN OF WHAT COUNTRY? U S A					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY					
17. FATHER'S NAME (First, Middle, Last) William Long				18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Harding							
19a. INFORMANT'S NAME (Type/Print) Henry C. Long				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3703 Nortonia Road Baltimore, Md 21216							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Md Nat Memorial Park		20c. LOCATION — City or Town, State Laurel, Md							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Portia Eason</i>				22. NAME AND ADDRESS OF FACILITY March F/H West 4300 Wabash Avenue							
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Sepsis</i> SEPSIS DUE TO (OR AS A CONSEQUENCE OF): Urinary tract infection Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <i>Urinary tract infection</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Renal failure</i> Renal failure								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER n/a		29d. DATE SIGNED (Month, Day, Year) <i>3/1/91</i>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) CHATILAWISSAM c/o Maryland General Hospital											
31. DATE FILED (Month, Day, Year) MAR 05 1991		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rendell</i>									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 05780

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>BESSIE LEVIN</b>				2. DATE OF DEATH MONTH <b>3</b> - DAY <b>1</b> - YEAR <b>91</b>		3. TIME OF DEATH <b>12:01 AM</b>	
4. SOCIAL SECURITY NUMBER <b>220-09-3006</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>84</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>12/9/1906</b>	
8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>				9a. FACILITY NAME (If not institution, give street and number) <b>OLD COURT NURSING HOME</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>RANDALLSTOWN</b>	
9c. COUNTY OF DEATH <b>BALTO</b>				10a. STATE <b>MARYLAND</b>			
10b. COUNTY <b>BALTIMORE</b>				10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>			
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>4607 REISTERSTOWN RD.</b>			
10f. ZIP CODE <b>21215</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: <b>XX</b>		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>TEACHER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>EDUCATION</b>			
17. FATHER'S NAME (First, Middle, Last) <b>ABRAHAM LEVIN</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>FANNIE LIPSITZ</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MR. JACK B. LEVIN</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2 CANDLEMAKER CT., APT. 306 BALTO., MD 21208</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>ARLINGTON (CHIZUK AMUNO) 3/3/91</b>		20c. LOCATION — City or Town, State <b>BALTIMORE, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>SOL LEVINSON &amp; BROS., INC. 6010 REISTERSTOWN RD. BALTIMORE, MD 21215</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Metastatic Cancer Throat</b> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <b>Hepatic Obstruction 2° AA</b> c. d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   						Approximate Interval Between Onset and Death <b>2 year</b>	
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>013999</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/1/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MB POGORIAN MD</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 05 1991</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 05781

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Samuel Lebin (SAMUEL ALBERT LEBIN)</b>		2. DATE OF DEATH MONTH <b>2</b> DAY <b>12</b> YEAR <b>91</b>		3. TIME OF DEATH <b>10:45</b> M
4. SOCIAL SECURITY NUMBER <b>388-01-8897</b>	5. SEX <b>1</b> M <b>2</b> F	6. AGE (In yrs. last birthday) <b>73</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>12/12/17</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Wisconsin</b>		9a. FACILITY NAME (If not institution, give street and number) <b>Levinale Geriatric Center &amp; Hosp</b>		
9b. CITY, TOWN OR LOCATION OF DEATH <b>Balto, Md</b>		9c. COUNTY OF DEATH		
10a. STATE <b>Md</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>
10d. INSIDE CITY LIMITS? <b>1</b> YES <b>2</b> NO		10e. STREET AND NUMBER <b>7208 VALLEY COUNTRY CT., APT. T-1</b>		
10f. ZIP CODE <b>21208</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
11. MARITAL STATUS <b>1</b> Never Married <b>2</b> Married <b>3</b> Widowed <b>4</b> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> YES <b>2</b> NO IF YES, GIVE WAR OR DATES <b>WWII - ARMY</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> YES <b>2</b> NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>12</b>		
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>BUTCHER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>FOOD</b>		
17. FATHER'S NAME (First, Middle, Last) <b>UNKNOWN LEBIN</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>JENNIE UNKNOWN</b>		
19a. INFORMANT'S NAME (Type/Print) <b>MRS. ROSE LEBIN</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7208 VALLEY COUNTRY CT., APT. T-1 BALTO., MD 21208</b>		
20a. METHOD OF DISPOSITION <b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>LUBAWITZ NUSACH ARI 3/3/91</b>		20c. LOCATION — City or Town, State <b>ROSEDALE, MD</b>
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Jay Lewis</b>		22. NAME AND ADDRESS OF FACILITY <b>SOL LEVINSON &amp; BROS., INC. 6010 REISTERSTOWN RD. BALTIMORE, MD 21215</b>		
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>PROBABLE MYOCARDIAL INFARCTION</b> a. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.				Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HISTORY OF MYOCARDIAL INFARCTION, INSULIN DEPENDENT DIABETES MELLITUS, ATHEROSCLEROTIC CARDIOVASCULAR DISEASE, OLD CEREBROVASCULAR ACCIDENT, CHRONIC RENAL FAILURE</b>				24a. WAS AN AUTOPSY PERFORMED? <b>1</b> YES <b>2</b> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1</b> YES <b>2</b> NO				
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> YES <b>2</b> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA OTHER: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify)		
27. MANNER OF DEATH <b>1</b> Natural <b>5</b> Pending Investigation <b>2</b> Accident <b>3</b> Suicide <b>4</b> Homicide <b>6</b> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY <b>M</b>	28c. INJURY AT WORK? <b>1</b> YES <b>2</b> NO
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER (Check only one) <b>1</b> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Elywan - ATTENDING PHYSICIAN</b>		29c. LICENSE NUMBER <b>25610</b>		29d. DATE SIGNED (Month, Day, Year) <b>3.1.91</b>
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>2434 W. BELVERDERE AVENUE, BALTIMORE, MARYLAND 21215</b>				
31. DATE FILED (Month, Day, Year) <b>MAR 05 1991</b>		32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>		

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 8 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.									
1. DECEASED'S NAME (First, Middle, Last) BAUGUESS, John Lewis				2. DATE OF DEATH MONTH 2 DAY 20 YEAR 91		3. TIME OF DEATH 8:12 a m							
4. SOCIAL SECURITY NUMBER 212-28-3136		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 59 YRS.		7. DATE OF BIRTH (Month, Day, Year) 3-31-31		8. BIRTHPLACE (State or Foreign Country) LANCASTER CO., PA.					
9a. FACILITY NAME (If not institution, give street and number) PERRY POINT VETERANS HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH PERRY POINT, MD.			9c. COUNTY OF DEATH CECIL Co.						
10a. STATE DE			10b. COUNTY KENT			10c. CITY, TOWN OR LOCATION TOWNSEND			10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				
10e. STREET AND NUMBER P.O. Box 271				10f. ZIP CODE 19734			10g. CITIZEN OF WHAT COUNTRY? U.S.A.						
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1-7-52 → 2-4-55		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: WHITE						
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) TRUCK DRIVER			16b. KIND OF BUSINESS/INDUSTRY TRUCKING						
17. FATHER'S NAME (First, Middle, Last) Glenn BAUGUESS				18. MOTHER'S NAME (First, Middle, Maiden Surname) ROSA KILBY									
19a. INFORMANT'S NAME (Type/Print) DARLENE KEEBLER				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13 KRANTZ MILL RD., NEW PROVIDENCE PA. 17560									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) INDIANTOWN GAP NATIONAL Cemetery			20c. LOCATION — City or Town, State						
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Fred Reynolds				22. NAME AND ADDRESS OF FACILITY REYNOLDS FUNERAL HOME PO-BOX 57, QUARRYVILLE, PA. 17566									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Squamous Cell Cancer of Right Lung DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. Chronic Obstructive Pulmonary Disease DUE TO (OR AS A CONSEQUENCE OF): c. Hypertension DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Undetermined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29b. SIGNATURE AND TITLE OF CERTIFIER Melicia Santos, MD		29c. LICENSE NUMBER NY 151094-I		29d. DATE SIGNED (Month, Day, Year) 2-20-91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MELICIA SANTOS, M.D. VAMC Perry Point, MD 21902								31. DATE FILED (Month, Day, Year) MAR 05 1991					
32. REGISTRAR'S SIGNATURE Julia Davidson-Randall													

1. The first part of the report is a general  
description of the project and its objectives.  
2. The second part is a detailed description of the  
methodology used in the study.  
3. The third part is a description of the results  
of the study.

4. The fourth part is a discussion of the  
results and their implications.  
5. The fifth part is a conclusion and  
recommendations for future research.

6. The sixth part is a list of references.  
7. The seventh part is an appendix containing  
additional data and figures.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last) <b>Minnie Lee MINNIE LEE</b>				2. DATE OF DEATH MONTH <b>5</b> DAY <b>4</b> YEAR <b>1991</b>	
4. SOCIAL SECURITY NUMBER <b>249-01-5606</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>88</b> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <b>4-1-02</b>		8. BIRTHPLACE (State or Foreign Country) <b>South Carolina</b>		3. TIME OF DEATH <b>7:30 A</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Lorin Nursing Home</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>	
9c. COUNTY OF DEATH <b>none</b>					
10a. STATE <b>Maryland</b>		10b. COUNTY <b>none</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore City</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
10e. STREET AND NUMBER <b>810 N. Washington St.</b>		10f. ZIP CODE <b>21205</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMY FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: <b>NEGROID</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5th grade</b> College (1-4 or 8+) <b>none</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Laundry</b>	
16b. KIND OF BUSINESS/INDUSTRY <b>Laundry</b>		17. FATHER'S NAME (First, Middle, Last) <b>Charlie Wilson</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Cora ?</b>	
19a. INFORMANT'S NAME (Type/Print) <b>Thelma Kinsborough</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>810 N. Washington St. Balto, Md. 21205</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Arbutus Memorial Park</b>		20c. LOCATION — City or Town, State <b>Baltimore, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Calvin B. Scruggs Sr.</b>		22. NAME AND ADDRESS OF FACILITY <b>Calvin B. Scruggs Funeral Home 1412 E. Preston St. Balto, Md. 21213</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>(Dementia - probable SDAT)</b> <b>Dementia - probable SDAT</b> DUE TO (OR AS A CONSEQUENCE OF): <b>(Anemia 2° chronic GI Blood loss)</b> <b>Anemia 2° chronic GI Blood loss</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Chronic Renal Insufficiency</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Staff Physician</b>		29c. LICENSE NUMBER <b>D28461</b>		29d. DATE SIGNED (Month, Day, Year) <b>3-4-91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Richard G. Bennett MD 5200 Eastern Ave Balto, MD 21224</b>					
31. DATE FILED (Month, Day, Year) <b>MAR 05 1991</b>		32. REGISTRAR'S SIGNATURE <b>Julia Davidson</b>			



91 05784

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ABRAHAM LEMON</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>01</b> YEAR <b>91</b>		3. TIME OF DEATH <b>7:35 P M</b>	
4. SOCIAL SECURITY NUMBER <b>250-36-0151</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>73</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>2-13-18</b>	
8. BIRTHPLACE (State or Foreign Country) <b>South Carolina</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Sinai Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>	
9c. COUNTY OF DEATH <b>none</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>none</b>	
10c. CITY, TOWN OR LOCATION <b>Baltimore City</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>2704 W. Garrison Avenue</b>	
10f. ZIP CODE <b>21215</b>				10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>NEGROID</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5th grade</b> Colleges (1-4 or 5+) <b>none</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Painter/Sand blaster</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Chemical Plant</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Isaac Lemon</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Ethel Smith</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Amanda Lemon</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2704 W. Garrison Ave. Balto, Md. 21215</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Woodlawn Cemetery</b>		20c. LOCATION — City or Town, State <b>Baltimore, Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Calvin B. Scruggs Jr.</b>				22. NAME AND ADDRESS OF FACILITY <b>Calvin B. Scruggs Funeral Home (21213) Baltimore, Maryland, 1412 E. Preston St.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Brain metastases</b>							
a. DUE TO (OR AS A CONSEQUENCE OF): <b>Lung carcinoma</b>							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> 1 <input type="checkbox"/> YES <input type="checkbox"/> NO	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>J. Downs MD</b>				29c. LICENSE NUMBER <b>D33627</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/4/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>J. Downs 120 Sister Pierre Drive Suite 406</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 05 1991</b>				32. REGISTRAR'S SIGNATURE <b>Gina Davidson</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR STATE REGISTRAR

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05785

1. DECEDENT'S NAME (First, Middle, Last) ELEANOR D. MACE				2. DATE OF DEATH MONTH DAY YEAR MARCH 4, 1991		3. TIME OF DEATH 1:30 A M	
4. SOCIAL SECURITY NUMBER 212-32-1347		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 88 YRS.	7. DATE OF BIRTH (Month, Day, Year) June 25, 1902		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) 2011 Stockton Rd.				9b. CITY, TOWN OR LOCATION OF DEATH Phoenix		9c. COUNTY OF DEATH Baltimore	
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Phoenix		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 2011 Stockton Rd.				10f. ZIP CODE 21131		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5 +		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Principal		16b. KIND OF BUSINESS/INDUSTRY Friends Upper School			
17. FATHER'S NAME (First, Middle, Last) J. Mears Dilworth				18. MOTHER'S NAME (First, Middle, Maiden Surname) Nellie E. Roberts			
19a. INFORMANT'S NAME (Type/Print) Otis E. Mace				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2011 Stockton Rd. Phoenix, Md. 21131			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) Greenmount Cemetery 3/5/91		20c. LOCATION — City or Town, State Baltimore, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE James F. Burnside, Jr.				22. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Baltimore, Md. 21212			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. colon cancer DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death 5 months	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Bruce Rosenberg				29c. LICENSE NUMBER D24121		29d. DATE SIGNED (Month, Day, Year) 3/4/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 28) (Type, Print) Bruce Rosenberg 1134 York Rd. Lutherville, Md. 21093							
31. DATE FILED (Month, Day, Year) MAR 05 1991				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall			





91 05786

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Paul M. Madison, Sr				2. DATE OF DEATH MONTH 2 DAY 27 YEAR 1991		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER 220-03-9454		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 80 YRS.		7. DATE OF BIRTH (Month, Day, Year) 12-23-1910	
8. BIRTHPLACE (State or Foreign Country) Md				9a. FACILITY NAME (If not institution, give street and number) 4001 Northern Parkway		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore	
9c. COUNTY OF DEATH				10a. STATE Md		10b. COUNTY	
10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER 4001 W. Northern Parkway				10f. ZIP CODE 21215		10g. CITIZEN OF WHAT COUNTRY? U S A	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY Bethlehem Steel	
17. FATHER'S NAME (First, Middle, Last) George Madison				18. MOTHER'S NAME (First, Middle, Maiden Surname) Sophia Washington			
19a. INFORMANT'S NAME (Type/Print) Lillian Allen				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4001 W. Northern Parkway Apt C Baltimore, Md 21215			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) Western Star Cemetery		20c. DATE 3491		20d. LOCATION — City or Town, State Catonsville, Md	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY March F/H West 4300 Wabash Avenue			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Metastatic Prostate carcinoma Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):						Approximate Interval Between Onset and Death 1983	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Venous stasis dehydration and malnutrition 2° anorexia 2° cancer						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) (Hospice)	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER D30717		29d. DATE SIGNED (Month/Day/Year) 3/1/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) Alicia A. Cool-Foley 201 E University Ave Baltimore, Md				31. DATE FILED (Month, Day, Year) MAR 05 1991			
32. REGISTRAR'S SIGNATURE AND TITLE <i>[Signature]</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				91 05787																			
				CERTIFICATE OF DEATH				REG. NO.																			
1. DECEDENT'S NAME (First, Middle, Last) <i>Tyrone McFadden</i>				2. DATE OF DEATH MONTH <i>02</i> DAY <i>28</i> YEAR <i>91</i>				3. TIME OF DEATH <i>10 40 AM</i>																			
4. SOCIAL SECURITY NUMBER <i>217-86-6263</i>		5. SEX <i>1</i> M <i>2</i> F		6. AGE (In yrs. last birthday) <i>32</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) <i>11/17/58</i>		8. BIRTHPLACE (State or Foreign Country) <i>MD</i>															
9a. FACILITY NAME (If not institution, give street and number) <i>Sinai Hospital</i>						9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i>				9c. COUNTY OF DEATH																	
10a. STATE <i>MD</i>				10b. COUNTY				10c. CITY, TOWN OR LOCATION <i>BALTIMORE</i>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO															
10e. STREET AND NUMBER <i>4004 PRIMROSE AVENUE</i>						10f. ZIP CODE <i>21215</i>				10g. CITIZEN OF WHAT COUNTRY?																	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i>															
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY																			
17. FATHER'S NAME (First, Middle, Last) <i>JOHN F. McFADDEN</i>						18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>MARY WARREN</i>																					
19a. INFORMANT'S NAME (Type/Print) <i>MARY PATTERSON</i>						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>4004 PRIMROSE AVE BALTIMORE, MD 21215</i>																					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <i>KING MEMORIAL PARK</i>				20c. LOCATION — City or Town, State <i>BALTIMORE, MARYLAND</i>																			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Leroy O. Dyett</i>						22. NAME AND ADDRESS OF FACILITY <i>LEROY O. DYETT &amp; SON FUNERAL HOME 4600 LIBERTY HEIGHTS AVENUE 21207</i>																					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>AIDS</i> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. <i>Pseudomonas endocarditis</i> c. <i>Acute Renal Failure</i>												Approximate Interval Between Onset and Death															
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) <i>M</i>				28b. TIME OF INJURY <i>M</i>				28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Robert R. Roby</i>				29c. LICENSE NUMBER <i>D37928</i>				29d. DATE SIGNED (Month, Day, Year) <i>2/28/91</i>															
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Robert R. Roby 2435 West Belvedere Ave Suite 22 Baltimore MD 21205</i>																											
31. DATE FILED (Month, Day, Year) <i>MAR 05 1991</i>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>																							



REG. NO.

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

 $0 + v_A$



91 05789

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>John A. Means</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>3</b> YEAR <b>91</b>		3. TIME OF DEATH <b>12:45 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>249-14-4756</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>73</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>6-10-17</b>	
8. BIRTHPLACE (State or Foreign Country) <b>S. CAROLINA</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Joseph Richey Hospice</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>	
9c. COUNTY OF DEATH							
10a. STATE <b>MARYLAND</b>				10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTIMORE CITY</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
10e. STREET AND NUMBER <b>1513 ABBOTSON STREET</b>				10f. ZIP CODE <b>21218</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Collegia (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>ANDREW MEANS</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname)			
19a. INFORMANT'S NAME (Type/Print) <b>REV. CHARLES BROWN</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3201 HILLSDALE ROAD: BALTIMORE, MD 21207</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>GARRISON FOREST CEMETERY</b>		20c. LOCATION — City or Town, State <b>OWINGS MILL, MD.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Leroy O. Dyett</i>				22. NAME AND ADDRESS OF FACILITY <b>LEROY O. DYETT &amp; SON FUNERAL HOME 4600 LIBERTY HEIGHTS AVENUE</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) <b>Ca of Prostate c</b> DUE TO (OR AS A CONSEQUENCE OF): <b>met's to the bone</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>Hospice</b>		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)	
28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Michael M. Hayes, MD</i>		29c. LICENSE NUMBER <b>D 02290</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/3/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>2402 Hemlock Ave. Balto 21214</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 05 1991</b>		32. REGISTRAR'S SIGNATURE <i>Gulia Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR THE FUNERAL HOME: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





91 05790

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Joseph A. Milano</i>				2. DATE OF DEATH MONTH <i>3</i> DAY <i>11</i> YEAR <i>1991</i>		3. TIME OF DEATH <i>1:45 p.m.</i>	
4. SOCIAL SECURITY NUMBER <i>218-12-8720</i>		5. SEX <i>1</i> <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <i>88</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) <i>Mar 15, 1902</i>	
8. BIRTHPLACE (State or Foreign Country) <i>Maryland</i>				9a. FACILITY NAME (If not institution, give street and number) <i>Homewood Hospital Center, South</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore City</i>	
9c. COUNTY OF DEATH		10a. STATE <i>Maryland</i>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <i>Baltimore City</i>	
10d. INSIDE CITY LIMITS? <i>1</i> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <i>1643 Argonne Drive</i>		10f. ZIP CODE <i>21218</i>		10g. CITIZEN OF WHAT COUNTRY? <i>United States</i>	
11. MARITAL STATUS <i>1</i> <input type="checkbox"/> Never Married <i>2</i> <input checked="" type="checkbox"/> Married <i>3</i> <input type="checkbox"/> Widowed <i>4</i> <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <i>1</i> <input type="checkbox"/> YES <i>2</i> <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <i>1</i> <input type="checkbox"/> YES <i>2</i> <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i> <i>6 yrs</i>		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Supervision</i>		17. KIND OF BUSINESS/INDUSTRY <i>Baltimore City Gov't.</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Dominic Milano</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Victoria</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Helen M. Milano</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1643 Argonne Drive Baltimore, Maryland 21218</i>			
20a. METHOD OF DISPOSITION <i>1</i> <input type="checkbox"/> Burial <i>2</i> <input checked="" type="checkbox"/> Cremation <i>3</i> <input type="checkbox"/> Removal from State <i>4</i> <input type="checkbox"/> Donation <i>5</i> <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Green Mount Cem. 3/4/91</i>		20c. LOCATION — City or Town, State <i>Baltimore Maryland</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Milton J. Knight Jr</i>				22. NAME AND ADDRESS OF FACILITY <i>Leonard J. Ruck, Inc. 5305 Harford Road 21214</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. <i>severe biventricular congestive Heart Failure</i>							
DUE TO (OR AS A CONSEQUENCE OF):							
b. <i>atherosclerotic coronary Heart disease</i>							
DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
<i>severe calcific Aortic stenosis</i>							
<i>chronic atrial Fibrillation</i>							
24a. WAS AN AUTOPSY PERFORMED? <i>1</i> <input type="checkbox"/> YES <i>2</i> <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <i>U/A</i> <i>1</i> <input type="checkbox"/> YES <i>2</i> <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <i>1</i> <input type="checkbox"/> YES <i>2</i> <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <i>1</i> <input checked="" type="checkbox"/> Inpatient <i>2</i> <input type="checkbox"/> ER/Outpatient <i>3</i> <input type="checkbox"/> DOA OTHER: <i>4</i> <input type="checkbox"/> Nursing Home <i>5</i> <input type="checkbox"/> Residence <i>6</i> <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <i>1</i> <input checked="" type="checkbox"/> Natural <i>5</i> <input type="checkbox"/> Pending Investigation <i>2</i> <input type="checkbox"/> Accident <i>6</i> <input type="checkbox"/> Could not be determined <i>3</i> <input type="checkbox"/> Suicide <i>4</i> <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <i>1</i> <input type="checkbox"/> YES <i>2</i> <input type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <i>1</i> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <i>2</i> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Marion L. ...</i>				29c. LICENSE NUMBER <i>D15698</i>		29d. DATE SIGNED (Month, Day, Year) <i>3/11/91</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>MARCOS GARCIA MD Homewood Hosp. Center, South, Balt. MD 21218</i>							
31. DATE FILED (Month, Day, Year) <i>MAR 05 1991</i>		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05791

1. DECEDENT'S NAME (First, Middle, Last) <b>Peter S. MENTO</b>				2. DATE OF DEATH MONTH DAY YEAR <b>March 3, 1991</b>		3. TIME OF DEATH <b>1:00 am</b>			
4. SOCIAL SECURITY NUMBER <b>218-01-0659</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>73</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Sept. 23, 1917</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Franklin Square Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Rossville</b>			9c. COUNTY OF DEATH <b>Baltimore County</b>		
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Rosedale</b>			10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER <b>1509 Brian Road</b>				10f. ZIP CODE <b>21237</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW II</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (9-12)</b> <b>12</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Bread Salesman Ret.</b>			16b. KIND OF BUSINESS/INDUSTRY		
17. FATHER'S NAME (First, Middle, Last) <b>Joseph Mento</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Agatha Policia</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Joseph H. Mento Jr.</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1505 Neighbors Avenue Baltimore, Md. 21237</b>					
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Entombment Moreland Memorial 3/6/91</b>		20c. LOCATION — City or Town, State <b>Baltimore Maryland</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Milton J. Knight Jr.</b>				22. NAME AND ADDRESS OF FACILITY <b>Leonard J. Ruck, Inc. 5305 Harford Road 21214</b>					
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>a. Electromechanical Dissociation</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. Coronary Artery Disease</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c. Congestive Heart Failure</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b>							Approximate Interval Between Onset and Death		
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO		
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28b. LOCATION (Street and Number or Rural Route Number, City or Town, State)		28c. DESCRIBE HOW INJURY OCCURRED		28d. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Kevin Scruggs</b>				29c. LICENSE NUMBER <b>D38543</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/3/91</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Kevin Scruggs, M.D., 9000 Franklin Square Drive, Baltimore, Maryland 21237</b>									
31. DATE FILED (Month, Day, Year) <b>MAR 05 1991</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>					



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				91 05792					
CERTIFICATE OF DEATH				REG. NO.									
1. DECEDENT'S NAME (First, Middle, Last) <del>XXXXXXXXXX</del> Martha E. Nelson				2. DATE OF DEATH MONTH DAY YEAR 2 26 1991				3. TIME OF DEATH 11:08A M					
4. SOCIAL SECURITY NUMBER 213-20 4717		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 99 YRS.		7. DATE OF BIRTH (Month, Day, Year) 4, 13, 1891		8. BIRTHPLACE (State or Foreign Country) Balto					
9a. FACILITY NAME (If not institution, give street and number) Mona's Care Center				9b. CITY, TOWN OR LOCATION OF DEATH <del>XXXXXXXXXX</del> Towson				9c. COUNTY OF DEATH Balto. County					
10a. STATE Md		10b. COUNTY Balto		10c. CITY, TOWN OR LOCATION Towson				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER 7001 N. Charles St.				10f. ZIP CODE 21204				10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) retired salesperson		16b. KIND OF BUSINESS/INDUSTRY Stieff Silver Co.									
17. FATHER'S NAME (First, Middle, Last) Louis C. Weller				18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Waldkoenig									
19a. INFORMANT'S NAME (Type/Print) Arthur L. Drager				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Light St. Bal. Md. 21202									
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Baltimore Cemetery		20c. LOCATION — City or Town, State Balto. Md.									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Thomas K. Drury</i>				22. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Balto. Md. 21212									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → s. <u>Stroke</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Emphysema</u>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>AH Outadun</i>				29c. LICENSE NUMBER D-12849		29d. DATE SIGNED (Month, Day, Year) 2-28-91			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) A H. GHILADI, MD 7600 OSLER Dr. Towson Md 21204													
31. DATE FILED (Month, Day, Year) MAR 05 1991				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randell</i>									



91 05793

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) TRUSS NELSON				2. DATE OF DEATH MONTH DAY YEAR 02-28-91		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER 213-30-4538		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		8. AGE (In yrs. last birthday) 55 YRS.		7. DATE OF BIRTH (Month, Day, Year) 1-29-1936	
9a. FACILITY NAME (If not institution, give street and number) 1232 KEVIN RD.		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE, MD				9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY		10c. CITY, TOWN OR LOCATION BALTIMORE CITY		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1232 KEVIN RD.				10f. ZIP CODE 21229		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11th College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY City of Balto			
17. FATHER'S NAME (First, Middle, Last) Samuel Nelson				18. MOTHER'S NAME (First, Middle, Maiden Surname) Alean Owens			
19a. INFORMANT'S NAME (Type/Print) Carolyn Nelson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1232 Kevin Road Baltimore, Md 21229			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Woodlawn Cemetery 3-5-91		20c. LOCATION — City or Town, State Baltimore, Md			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Portia Ebron</i>				22. NAME AND ADDRESS OF FACILITY WM.C. MARCH F.H. 4300 WABASH AVE.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>lung cancer</u> DUE TO (OR AS A CONSEQUENCE OF): Sequitely flat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. c. d. Approximate Interval Between Onset and Death 2 years							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide 4 <input type="checkbox"/>		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Eric Rowinsky</i>				29c. LICENSE NUMBER M996		29d. DATE SIGNED (Month, Day, Year) 3/4/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Eric Rowinsky M.D. Johns Hopkins Onc Center Balt., MD 21205							
31. DATE FILED (Month, Day, Year) MAR 05 1991		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05794

1. DECEDENT'S NAME (First, Middle, Last) <b>Victoria Ann Damiano Nigro</b>				2. DATE OF DEATH MONTH DAY YEAR <b>March 4, 1991</b>		3. TIME OF DEATH <b>5:50 am</b> M			
4. SOCIAL SECURITY NUMBER <b>058-03-8020</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>79</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Oct 2, 1911</b>		8. BIRTHPLACE (State or Foreign Country) <b>New York</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Stella Maris Hospice</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Towson</b>			9c. COUNTY OF DEATH <b>Baltimore</b>		
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore County</b>		10c. CITY, TOWN OR LOCATION <b>Timonium</b>			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER <b>3 Brooking Court</b>				10f. ZIP CODE <b>21093</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>4 years</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Statistician</b>			16b. KIND OF BUSINESS/INDUSTRY <b>Insurance</b>				
17. FATHER'S NAME (First, Middle, Last) <b>Vincent Damiano</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Angelena Concistre</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Mr. Victor P. Nigro</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3 Brooking Court, Timonium, MD 21093</b>					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Dulaney Valley Mausoleum</b>			20c. LOCATION — City or Town, State <b>Timonium, Maryland</b>				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Martin D. Lawson</i> <b>Martin D. Lawson</b>				22. NAME AND ADDRESS OF FACILITY <b>Dulaney Valley Home of Lemmon-Mitchell-Wiedefeld, Inc. 10 W. Padonia Road, Timonium, MD 21093</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardio-Pulmonary Arrest</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <b>Alzheimer's Disease</b> DUE TO (OR AS A CONSEQUENCE OF):  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Alzheimers Disease</b>							Approximate interval Between Onset and Death		
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John Alan Baldanza</i> <b>J. Alan Baldanza MD</b>				29c. LICENSE NUMBER <b>D19166</b>		29d. DATE SIGNED (Month, Day, Year) <b>March 4, 1991</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>J. Alan Baldanza MD 10629 York Road Cockeysville, Md 21030</b>									
31. DATE FILED (Month, Day, Year) <b>MAR 05 1991</b>		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randell</i>							



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				CERTIFICATE OF DEATH		REG. NO. 91 05795			
1. DECEDENT'S NAME (First, Middle, Last) Della NMI NUNLEY						2. DATE OF DEATH MONTH 3 DAY 1 YEAR 91		3. TIME OF DEATH 3:00 P.M.			
4. SOCIAL SECURITY NUMBER 403-22-5751		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 88 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov. 16, 1902		8. BIRTHPLACE (State or Foreign Country) Kentucky			
9a. FACILITY NAME (If not institution, give street and number) Franklin Square Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Rossville			9c. COUNTY OF DEATH Baltimore				
RESIDENCE OF DECEDENT											
10a. STATE Md.		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Essex		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER 806 Runkles Terrace				10f. ZIP CODE 21221		10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4th College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		16b. KIND OF BUSINESS/INDUSTRY					
17. FATHER'S NAME (First, Middle, Last) Z.T. Stacy				18. MOTHER'S NAME (First, Middle, Maiden Surname) Rose Coffey							
19a. INFORMANT'S NAME (Type/Print) James Bowman				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 806 Runkles Terrace Baltimore MD.21221							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Glen Haven Cemetery		20c. LOCATION — City or Town, State Baltimore Md.					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Connelly Funeral Home</i>				22. NAME AND ADDRESS OF FACILITY ConnellyFuneralHome300MAceAve.21221							
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Anterior Myocardial infarction DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28b. DESCRIBE HOW INJURY OCCURRED				28c. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Timothy C. Murray, M.D.</i>						29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year)			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Timothy Murray 9000 Franklin Square Dr. Baltimore M.D. 21237											
31. DATE FILED (Month, Day, Year) MAR 05 1991				32. REGISTRAR'S SIGNATURE <i>John Davidson</i>							



91 05796

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MARIE CHRISTINE NELSON</b>				2. DATE OF DEATH MONTH <b>02</b> DAY <b>27</b> YEAR <b>1991</b>		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER <b>215-07-2290</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) <b>89</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>02-26-1902</b>	
9a. FACILITY NAME (If not Institution, give street and number) <b>Dulaney-Towson Nursing Home</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Towson</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Dundalk</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1531 Vesper Avenue</b>				10f. ZIP CODE <b>21222</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8th Grade</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Francis Higgins</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Christine Foster</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mrs. Ethel N. Morrow</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3625 Raymonn Avenue, Baltimore, MD 21213</b>			
20. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Gardens of Faith Cem. 3/2/91</b>		DATE <b>Baltimore, MD</b>		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Scott P. Coander</b>				22. NAME AND ADDRESS OF FACILITY <b>Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue, Baltimore, MD 21222</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>SENILE DEMENTIA</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ARTERIAL INSUFFICIENCY</b> <b>ATRIAL FIBRILLATION</b> <b>CEREBROVASCULAR ACCIDENT</b>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
26. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		27. DATE OF INJURY (Month, Day, Year)		28. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>JEFF SCHULTZ MD</b>		29c. LICENSE NUMBER <b>D33728</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/28/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>9712 BLAIR RD #204, BALTIMORE, MD 21236</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 05 1991</b>		32. REGISTRAR'S SIGNATURE <b>Lia Davidson-Rendell</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>KING David PRICE</b>				2. DATE OF DEATH MONTH DAY YEAR <b>03 02 91</b>		3. TIME OF DEATH <b>8:30</b>	
4. SOCIAL SECURITY NUMBER <b>250-32-0033</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>65</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>10-11-25</b>	
8. BIRTHPLACE (State or Foreign Country) <b>S.C.</b>				9a. FACILITY NAME (If not institution, give street and number) <b>ST. AGNES HOSPITAL</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>	
9c. COUNTY OF DEATH				10a. STATE <b>MD</b>		10b. COUNTY	
10c. CITY, TOWN OR LOCATION <b>BALTO.</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>1420 Aisgwith St</b>	
10f. ZIP CODE <b>21202</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Negro</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input checked="" type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Labor</b>		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <b>Samuel Mack Price</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Julie Feaster</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MARY Price</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1420 N. Aisgwith St. BALTO. MD 21202</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Memorial Gardens 3/1</b>		20c. LOCATION — City or Town, State <b>Chester S.C.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Betts Funeral Home</b>				22. NAME AND ADDRESS OF FACILITY <b>1125 N. Caroline St</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Hypertensive and atherosclerotic cardiovascular disease</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>A.M. Dixon</b>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>03/03/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>A.M. Dixon 111 PENN STREET, BALTIMORE, MARYLAND 21201</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 05 1991</b>				32. REGISTRAR'S SIGNATURE <b>Lia Davidson-Randall</b>			

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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TABLE 1



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				CERTIFICATE OF DEATH				REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last) ADAM JOSEPH POPLAR						2. DATE OF DEATH MONTH 3 DAY 1 YEAR 91		3. TIME OF DEATH 11:45A M							
4. SOCIAL SECURITY NUMBER 215-18-7765		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 91 YRS.		7. DATE OF BIRTH (Month, Day, Year) 3-23-99		8. BIRTHPLACE (State or Foreign Country) Maryland							
9a. FACILITY NAME (If not institution, give street and number) Harbor Hospital Center						9b. CITY, TOWN OR LOCATION OF DEATH Baltimore				9c. COUNTY OF DEATH City					
10a. STATE MD		10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Glen Burnie				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 502 Winton Ave.				10f. ZIP CODE 21061				10g. CITIZEN OF WHAT COUNTRY? U.S.A.							
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5th College (1-4 or 5+) None				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Mechanic				16b. KIND OF BUSINESS/INDUSTRY ILA Local							
17. FATHER'S NAME (First, Middle, Last) Joseph Poplar						18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Unknown									
19a. INFORMANT'S NAME (Type/Print) Agnes K. Poplar				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same As #10											
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Glen Haven Memorial Park				20c. LOCATION — City or Town, State Glen Burnie, Md.							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Harold B. Wilson</i>				22. NAME AND ADDRESS OF FACILITY Singleton Funeral Home 1 Second Ave. S.W. Glen Burnie, Md. 21061											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Respiratory Arrest - Cardiac arrest</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>CHE</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>Pneumonia</i> DUE TO (OR AS A CONSEQUENCE OF): d. Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29b. SIGNATURE AND TITLE OF CERTIFIER <i>Jack Soliman MD</i>		29c. LICENSE NUMBER <i>House Staff</i>		29d. DATE SIGNED (Month, Day, Year) <i>3-1-91</i>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>JACK SOLIMAN HNC Balt MD 21230</i>															
31. DATE FILED (Month, Day, Year) <i>MAR 5 1991</i>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rendell</i>											



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91 05799

FOR  
STATE  
1 - REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ROSE MARIE PICKETT				2. DATE OF DEATH MONTH 03 DAY 01 YEAR 1991		3. TIME OF DEATH 5:30 P M	
4. SOCIAL SECURITY NUMBER 219-40-3083		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 48 YRS.		7. DATE OF BIRTH MONTH 03 DAY 01 YEAR 1942	
9a. FACILITY NAME (If not institution, give street and number) 30 LANDMARK COURT				9b. CITY, TOWN OR LOCATION OF DEATH ESSEX		9c. COUNTY OF DEATH BALTIMORE	
RESIDENCE OF DECEDENT							
10a. STATE Md.		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Esse x		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 30 Landmark Court				10f. ZIP CODE 21221		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10th College (1-4 or 8+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) John J. Cavallio				18. MOTHER'S NAME (First, Middle, Maiden Surname) Rose Sciancalepore			
19a. INFORMANT'S NAME (Type/Print) Rose Cavallio				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 423 Virginia Ave. Baltimore Md. 21221			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 8 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Oak Lawn Cemetery 3/5/91		20c. LOCATION — City or Town, State Baltimore Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Connelly Funeral Home</i>				22. NAME AND ADDRESS OF FACILITY ConnellyFuneralHome300MAceAve.21221			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Smoke Inhalation</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 03 01 1991		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) Home		28d. DESCRIBE HOW INJURY OCCURRED HOUSEFIRE			
				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 30 LANDMARK CT.			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER OCME		29d. DATE SIGNED (Month, Day, Year) 03 02 1991	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) A.M. - Dixon 111 PENN STREET BALTIMORE, MARYLAND 01201							
31. DATE FILED (Month, Day, Year) MAR 05 1991		32. REGISTRAR'S SIGNATURE <i>Gula Davidson-Randell</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 05800

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) SHIRLEY PURNELL				2. DATE OF DEATH MONTH DAY YEAR MARCH 3 1991		3. TIME OF DEATH 7:03 a.m. M	
4. SOCIAL SECURITY NUMBER 214-42-8585		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) 46 YRS.		7. DATE OF BIRTH (Month, Day, Year) 10-31-44	
9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH BALTIMORE CITY			
RESIDENCE OF DECEDENT							
10a. STATE MD.		10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 3950 Dolfield Avenue				10f. ZIP CODE 21215		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Secretary		16b. KIND OF BUSINESS/INDUSTRY Towson State Univ.			
17. FATHER'S NAME (First, Middle, Last) Harvey Dixon				18. MOTHER'S NAME (First, Middle, Maiden Surname) Agnes Dale			
19a. INFORMANT'S NAME (Type/Print) Michael Purnell				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3950 Dolfield Avenue Balto., MD. 21215			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Arbutus Memorial Pk.		20c. LOCATION — City or Town, State Balto., MD.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dorothy Hector		#281		22. NAME AND ADDRESS OF FACILITY E.L. Phillips F/H 1721-27 N. Monroe Balto., MD. 21217			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Sepsis b. Staphylococcal bacteremia c. d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death 24 hours. 4 days.
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ovarian cancer							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined					
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Laura Meritt MD J5323				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) 3-3-91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Laura Meritt MD 9000 Franklin Sq. Dr. Balto. MD 21237							
31. DATE FILED (Month, Day, Year) MAR 05 1991		32. REGISTRAR'S SIGNATURE Julia Davidson-Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146  
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05801

1. DECEASED'S NAME (First, Middle, Last) <b>Rollins Ernest</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>1</b> YEAR <b>91</b>				3. TIME OF DEATH <b>0939</b> M					
4. SOCIAL SECURITY NUMBER <b>214 20-5518</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (If yrs. last birthday) <b>64</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>11-12-26</b>		8. BIRTHPLACE (State or Foreign Country) <b>MD.</b>					
9a. FACILITY NAME (If not institution, give street and number) <b>Good Samaritan Hosp.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>				9c. COUNTY OF DEATH					
RESIDENCE OF DECEASED													
10a. STATE <b>MD</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTIMORE, CITY</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
10e. STREET AND NUMBER <b>616 RADNOR AVE.</b>				10f. ZIP CODE <b>21239</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>ARMY</b>		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>							
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10th</b> College (1-4 or 5+) <b>BETH STEEL</b>				16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>BETH STEEL</b>		16b. KIND OF BUSINESS/INDUSTRY							
17. FATHER'S NAME (First, Middle, Last) <b>HORACE ROLLINS</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ISABELLA GRIFFIN</b>									
19a. INFORMANT'S NAME (Type/Print) <b>GERALDINE ROLLINS</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>616 RADNOR AVE./BALTIMORE, MD. 21239</b>									
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>GARRISON FOREST VET. CEM.</b>		20c. LOCATION — City or Town, State <b>OWINGS MILLS, MD.</b>									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Gladys Wanner</b>				22. NAME AND ADDRESS OF FACILITY <b>WM.C. MARCH F.H. 1101 E. NORTH AVE.</b>									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Pulmonary Embolus</b> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): <b>Metastatic Cancer of the</b> c. DUE TO (OR AS A CONSEQUENCE OF): <b>Deep Venous Thrombosis</b> d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death <b>~ 1 1/2 hrs</b> <b>~ 4 hrs</b>													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>S/P Hemicolectomy 2nd to bleed</b>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO								26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28t. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29b. SIGNATURE AND TITLE OF CERTIFIER <b>Ziad Marza</b>		29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>3-1-91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Ziad Marza MD - Good Samaritan Hospital</b>													
31. DATE FILED (Month, Day, Year) <b>3 MAR 05 1991</b>				32. REGISTRAR'S SIGNATURE <b>Juana Davidson-Randall</b>									





91 05802

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>HARRY RUDICK</b>				2. DATE OF DEATH MONTH DAY YEAR <b>MAR. 2, 1991</b>		3. TIME OF DEATH <b>6:30 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>216-03-1609</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		8. AGE (In yrs. last birthday) <b>72</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>4/14/1918</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>3318 CLARKS LA., APT. B</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		9c. COUNTY OF DEATH <b>MARYLAND</b>	
10a. STATE <b>MARYLAND</b>				10b. COUNTY <b>BALTIMORE</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>3318 CLARKS LA., APT. B</b>				10f. ZIP CODE <b>21215</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WWII-ARMY</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>ORDERING CLERK</b>		16b. KIND OF BUSINESS/INDUSTRY <b>ZAMOSKI &amp; CO.</b>			
17. FATHER'S NAME (First, Middle, Last) <b>SAMUEL RUDICK</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>REBECCA NOVAK</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MRS. SYLVIA T. RUDICK</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3318 CLARKS LA., APT. B BALTIMORE, MD 21215</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>SHAAREI TFILOH</b>		DATE <b>3/4/91</b>		20c. LOCATION — City or Town, State <b>BALTIMORE, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>SOL LEVINSON &amp; BROS., INC. 6010 REISTERSTOWN RD. BALTIMORE, MD 21215</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>BLADDER CARCINOMA</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  <b>MD</b>				29c. LICENSE NUMBER <b>035606</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/2/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>SAMUEL ZILBER 711 W 40TH ST BAL MD 21211</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 05 1991</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH REG. NO.

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MARY E. ROBERTS</b>		2. DATE OF DEATH MONTH DAY YEAR <b>3 3 91</b>		3. TIME OF DEATH <b>9:30 PM</b>	
4. SOCIAL SECURITY NUMBER <b>212-42-8404</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs., last birthday) YRS. <b>48</b>	
		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. FACILITY NAME (If not institution, give street and number) <b>Francis Scott Key Medical Center</b>		7b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>		7c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT					
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore City</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore City</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO					
10e. STREET AND NUMBER <b>306 South Conkling Street</b>		10f. ZIP CODE <b>21224</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY	
<b>Elementary/Secondary (K-12)</b> <b>9th Grade</b>		<b>College (1-4 or 5+)</b>		<b>Homemaker Own Home</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Lamar E. Clark</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Edwina M. Baronowski</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Charles E. Roberts Jr.</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>306 South Conkling St., Baltimore, MD 21224</b>			
20a. METHOD OF DISPOSITION 1X Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Oak Lawn Cemetery 3/7/91</b>		20c. LOCATION — City or Town, State <b>Baltimore, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY <b>Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue, Baltimore, MD 21222</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>C.O.P.D. End stage</b>  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST }  a. _____ DUE TO (OR AS A CONSEQUENCE OF):  b. _____ DUE TO (OR AS A CONSEQUENCE OF):  c. _____ DUE TO (OR AS A CONSEQUENCE OF):  d. _____		Approximate Interval Between Onset and Death <b>10yrs.</b>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  _____		24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> XEROutpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28c. INJURY AT WORK?		28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <b>M. Welinsky M.D.</b>		29c. LICENSE NUMBER <b>D-27921</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/3/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>M. Welinsky 3411 Bancroft St. Balt.-21224</b>					
31. DATE FILED (Month, Day, Year) <b>MAR 5 1991</b>		32. REGISTRAR'S SIGNATURE 			



91 05804

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>GEORGE SMITH</u>				2. DATE OF DEATH MONTH <u>3</u> DAY <u>2</u> YEAR <u>91</u>		3. TIME OF DEATH <u>1503</u> M			
4. SOCIAL SECURITY NUMBER <u>213122456</u>		5. SEX <u>1</u> M <u>2</u> F		6. AGE (In yrs. last birthday) <u>71</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>3/3/19</u>		8. BIRTHPLACE (State or Foreign Country) <u>MD</u>	
9a. FACILITY NAME (If not institution, give street and number) <u>University Hospital</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>BALTIMORE</u>			9c. COUNTY OF DEATH		
10a. STATE <u>MD</u>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <u>Baltimore</u>			10d. INSIDE CITY LIMITS? <u>1</u> YES <u>2</u> NO		
10e. STREET AND NUMBER <u>1418 N. Fulton Avenue</u>				10f. ZIP CODE <u>21217</u>		10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
11. MARITAL STATUS <u>1</u> Never Married <u>2</u> Married <u>3</u> Widowed <u>4</u> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <u>1</u> YES <u>2</u> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <u>1</u> YES <u>2</u> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <u>Black</u>		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>College (1-4 or 5+)</u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)			16b. KIND OF BUSINESS/INDUSTRY				
17. FATHER'S NAME (First, Middle, Last) <u>George Smith</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Alberta Vessells</u>					
19a. INFORMANT'S NAME (Type/Print) <u>Mrs. Lessie Smith</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1418 N. Fulton Avenue, Balto., MD 21217</u>					
20a. METHOD OF DISPOSITION <u>1</u> Burial <u>2</u> Cremation <u>3</u> Removal from State <u>4</u> Donation <u>5</u> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) <u>Arbutus Memorial</u>		20c. LOCATION — City or Town, State <u>Baltimore CO., MD</u>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Joseph L. Russ (dop)</u>				22. NAME AND ADDRESS OF FACILITY <u>Joseph L. Russ funeral Home, 2222-26 West North Avenue, Balto., MD 21216</u>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>MULTIPLE ORGAN SYSTEM FAILURE</u> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <u>UPPER GASTROINTESTINAL HEMORRHAGE</u> DUE TO (OR AS A CONSEQUENCE OF): <u>GASTRIC ULCER</u> DUE TO (OR AS A CONSEQUENCE OF):  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>END STAGE RENAL DISEASE</u> <u>MULTIPLE MYELOMA</u>							Approximate interval Between Onset and Death		
24a. WAS AN AUTOPSY PERFORMED? <u>1</u> YES <u>2</u> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <u>1</u> YES <u>2</u> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <u>1</u> YES <u>2</u> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <u>1</u> Inpatient <u>2</u> ER/Outpatient <u>3</u> DOA OTHER: <u>4</u> Nursing Home <u>5</u> Residence <u>6</u> Other (Specify)							
27. MANNER OF DEATH <u>1</u> Natural <u>5</u> Pending Investigation <u>2</u> Accident <u>6</u> Could not be determined <u>3</u> Suicide <u>4</u> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? <u>1</u> YES <u>2</u> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <u>1</u> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <u>2</u> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Douglas M. Geetha MD</u>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <u>3/2/91</u>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>DOUGLAS GEETHA UMMS BALTIMORE MD 21201</u>									
31. DATE FILED (Month, Day, Year) <u>MAR 03 1991</u>		32. REGISTRAR'S SIGNATURE <u>Lelia Davidson-Randall</u>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 05805

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Frances R. Smith				2. DATE OF DEATH MONTH DAY YEAR March 3, 1991		3. TIME OF DEATH 6:00 A M	
4. SOCIAL SECURITY NUMBER 217-01-7583		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 72 YRS.	7. DATE OF BIRTH (Month, Day, Year) OCT. 14, 1918		8. BIRTHPLACE (State or Foreign Country) PENNA.	
9a. FACILITY NAME (If not institution, give street and number) 35 S. EAST AVE.				9b. CITY, TOWN OR LOCATION OF DEATH 21224		9c. COUNTY OF DEATH -- -- --	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY -- -- --		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 45 S. EAST AVENUE				10f. ZIP CODE 21224		10g. CITIZEN OF WHAT COUNTRY? U. S. A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) NA College (1-4 or 5+) NA		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) INSPECTOR		16b. KIND OF BUSINESS/INDUSTRY PAPER CUP COMPANY			
17. FATHER'S NAME (First, Middle, Last) GEORGE PIETRUSZEWSKI				18. MOTHER'S NAME (First, Middle, Maiden Surname) HELEN KUCZ			
19a. INFORMANT'S NAME (Type/Print) DONALD SMITH (SON)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 35 S. EAST AVE., BALTIMORE, MD. 21224			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) HOLY ROSARY CEMETERY		20c. LOCATION — City or Town, State BALTIMORE, MD.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Schimunek Funeral Home, Inc. 3331 Brehms Lane Balto., Md. 21213			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Severe Chronic Obstructive Pulmonary disease					
		b. Coronary artery disease					
		c. Atherosclerotic heart disease					
		d. Peripheral vascular disease					
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atrial Fibrillation Hypertension							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Neenanhas M.D.				29c. LICENSE NUMBER D 25423		29d. DATE SIGNED (Month, Day, Year) 3/5/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Randallstown Medical Centre 5310 Old Court # 301 Randallstown, Md. 21133.							
31. DATE FILED (Month, Day, Year) MAR 05 1991		32. REGISTRAR'S SIGNATURE John Davidson-Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





91-1137-510

91 05806

FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Aaron Sturman</b>				2. DATE OF DEATH MONTH DAY YEAR <b>02 28 1991</b>		3. TIME OF DEATH <b>5:40 P M</b>	
4. SOCIAL SECURITY NUMBER <b>220-72-7829</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>74</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>7/07/1916</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>3605 Fairview Avenue</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>		9c. COUNTY OF DEATH	
10a. STATE <b>MARYLAND</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>3605 FAIRVIEW AVE.</b>				10f. ZIP CODE <b>21216</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>12</b> Elementary/Secondary (0-12) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>TELETYPE OPERATOR</b>		16b. KIND OF BUSINESS/INDUSTRY <b>RAILROAD</b>			
17. FATHER'S NAME (First, Middle, Last) <b>ISADORE STURMAN</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ANNIE KESSLER</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MRS. LILLIAN BERNSTEIN</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8903 FREESTONE AVE. RICHMOND, VA 23229</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>MOSES MONTEFIORE</b>		DATE <b>3/4/91</b>		20c. LOCATION — City or Town, State <b>RICHMOND, VA</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ellen Lee Levinson</i>				22. NAME AND ADDRESS OF FACILITY <b>SOL LEVINSON &amp; BROS., INC.</b> <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Arteriosclerotic cardiovascular disease</i>  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Mario F. Golub, Jr.</i>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>03 01 1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MARIO F. GOLUB, JR., MD 111 Penn Street, Baltimore Maryland 21201</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 05 1991</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				CERTIFICATE OF DEATH				REG. NO. 91 05807					
1. DECEDENT'S NAME (First, Middle, Last) <b>Rose Siegel</b>								2. DATE OF DEATH MONTH <b>02</b> DAY <b>28</b> YEAR <b>91</b>				3. TIME OF DEATH <b>1130 A.M.</b>					
4. SOCIAL SECURITY NUMBER <b>216-03-0470</b>				5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>86</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>2/23/05</b>		8. BIRTHPLACE (State or Foreign Country) <b>LITHUANIA</b>							
9a. FACILITY NAME (If not institution, give street and number) <b>Sinai Hospital</b>								9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>				9c. COUNTY OF DEATH					
10a. STATE <b>MARYLAND</b>				10b. COUNTY				10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
10e. STREET AND NUMBER <b>6320 GREENSPRING AVE.</b>								10f. ZIP CODE <b>21209</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>12</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>BUYER</b>				16b. KIND OF BUSINESS/INDUSTRY <b>DEPARTMENT STORE</b>									
17. FATHER'S NAME (First, Middle, Last) <b>ABRAHAM SCHERR</b>								18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>FANNIE CAPLAN</b>									
19a. INFORMANT'S NAME (Type/Print) <b>MRS. HARRIET MILLER</b>								19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2901 FALLSTAFF RD., APT. 408 BALTIMORE, MD 21209</b>									
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>BETH TFILOH 3/1/91</b>				20c. LOCATION — City or Town, State <b>BALTIMORE, MD</b>									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>								22. NAME AND ADDRESS OF FACILITY <b>SOL LEVINSON &amp; BROS., INC. 6010 RIVINGTON RD. BALTIMORE, MD 21215</b>									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Cardiac Arrest</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>b. Sepsis</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c. Respiratory Failure</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b>												Approximate Interval Between Onset and Death					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>COPD, ASCVD</b>												24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)													
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED							
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												29b. SIGNATURE AND TITLE OF CERTIFIER <b>Vicki Star MD</b>		29c. LICENSE NUMBER <b>9465</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/28/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Vicki Star Sinai Hosp Belvedere E Greenspring</b>																	
31. DATE FILED (Month, Day, Year) <b>MAR 05 1991</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>													



91 05808

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ERWIN S. Stern</b>		2. DATE OF DEATH MONTH <b>2</b> DAY <b>28</b> YEAR <b>91</b>		3. TIME OF DEATH <b>1005 A</b>	
4. SOCIAL SECURITY NUMBER <b>220-14-0120</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>70</b> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <b>7/13/20</b>		8. BIRTHPLACE (State or Foreign Country) <b>GERMAN Y</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>LEVINDALE</b>			9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		9c. COUNTY OF DEATH
RESIDENCE OF DECEDENT					
10a. STATE <b>MARYLAND</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
10e. STREET AND NUMBER <b>3202 LABYRINTH RD.</b>			10f. ZIP CODE <b>21208</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>PRESSER</b>		17. KIND OF BUSINESS/INDUSTRY <b>CLOTHING</b>	
17. FATHER'S NAME (First, Middle, Last) <b>JULES STERN</b>			18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>CELLY WEIL</b>		
19a. INFORMANT'S NAME (Type/Print) <b>CHARLES STERN</b>			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>629 LEAFYDALE TERRACE BALTO., MD 21208</b>		
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>SHAAREI ZION - 3/1/1991</b>		20c. LOCATION — City or Town, State <b>ROSEDALE, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Sydney L. Stillman</i>		22. NAME AND ADDRESS OF FACILITY <b>SOL LEVINSON &amp; BROS., INC. 6010 REISTERSTOWN RD. BALTIMORE, MD 21215</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Metastatic carcinoma of colon</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.					Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
					24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> 1 <input type="checkbox"/> YES <input type="checkbox"/> NO	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <b>JOSEPH GALLO Joseph Gallo MD</b>			29c. LICENSE NUMBER <b>D31479</b>		29d. DATE SIGNED (Month, Day, Year) <b>2-28-91</b>
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>LEVINDALE GERIATRIC CTR. Baltimore Md 21215</b>					
31. DATE FILED (Month, Day, Year) <b>MAR 05 1991</b>		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randella</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 05809

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Scherr Irene</u> (IRENE SCHERR)				2. DATE OF DEATH MONTH <u>02</u> DAY <u>28</u> YEAR <u>1991</u>		3. TIME OF DEATH <u>4:30</u> A M		
4. SOCIAL SECURITY NUMBER <u>215-24-0778</u>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>71</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>6/28/1919</u>		
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9a. FACILITY NAME (If not institution, give street and number) SINAI HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		
9c. COUNTY OF DEATH				10a. STATE MARYLAND		10b. COUNTY BALTIMORE		
10c. CITY, TOWN OR LOCATION BALTIMORE				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 6610 WICKFIELD RD.		
10f. ZIP CODE 21209				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (14 or 5+) <u>College</u>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE		16b. KIND OF BUSINESS/INDUSTRY AT HOME		
17. FATHER'S NAME (First, Middle, Last) JULIUS FRIED				16. MOTHER'S NAME (First, Middle, Maiden Surname) ROSE SHAPIRO				
19a. INFORMANT'S NAME (Type/Print) DR. JULES SCHERR				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 TIMBER WAY CT. REISTERSTOWN, MD 21136				
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) BALTIMORE HEBREW		20c. LOCATION — City or Town, State 3/1/91 REISTERSTOWN, MD		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Cellenae Levenson</u>				22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215				
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Sepsis</u> DUE TO (OR AS A CONSEQUENCE OF):								
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF):								
c. DUE TO (OR AS A CONSEQUENCE OF):								
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <u>A. Young MD PGY-1</u>		29c. LICENSE NUMBER		
29d. DATE SIGNED (Month, Day, Year) <u>2/28/91</u>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>S. Young Sinai Hospital</u>				
31. DATE FILED (Month, Day, Year) MAR 05 1991				32. REGISTRAR'S SIGNATURE <u>Julia Davidson-Rhodes</u>				

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				CERTIFICATE OF DEATH				REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last) <b>WALTER SIMMS</b>				2. DATE OF DEATH MONTH <b>03</b> DAY <b>02</b> YEAR <b>91</b>				3. TIME OF DEATH <b>1240</b> A.M.							
4. SOCIAL SECURITY NUMBER <b>218-12-0217</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>85</b> YRS.		IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS. HOURS _____ MIN. _____		7. DATE OF BIRTH (Month, Day, Year) <b>9/12/1905</b>		8. BIRTHPLACE (State or Foreign Country) <b>Virginia</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Liberty Medical Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>				9c. COUNTY OF DEATH							
10a. STATE <b>MARYLAND</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTIMORE CITY</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
10e. STREET AND NUMBER <b>3619 W. FOREST PARK</b>				10f. ZIP CODE <b>21215</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) _____ College (1-4 or 5+) _____				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY							
17. FATHER'S NAME (First, Middle, Last) <b>?</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>?</b>											
19a. INFORMANT'S NAME (Type/Print) <b>RICHARD DOTSON</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3619 W. FOREST PARK BALTO., MD 21215</b>											
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>WESTERN STAR CEMETERY</b>		20c. LOCATION — City or Town, State <b>CATONSVILLE, MD</b>											
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Leroy O. Dyett</i>				22. NAME AND ADDRESS OF FACILITY <b>LEROY O. DYETT &amp; SON FUNERAL HOME 4600 LIBERTY HEIGHTS AVENUE 21207</b>											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>septic shock</b> <b>colon CA</b> <b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. _____								Approximate Interval Between Onset and Death							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____											
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M _____		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED							
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)											
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Kanti Zamboni</i>				29c. LICENSE NUMBER <b>D 40193</b>		29d. DATE SIGNED (Month, Day, Year) <b>03-02-91</b>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)															
31. DATE FILED (Month, Day, Year) <b>MAR 05 1991</b>				32. REGISTRAR'S SIGNATURE <i>J. Davidson-Randall</i>											



91 05811

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Willie E. Smith</i>				2. DATE OF DEATH MONTH DAY YEAR <i>2-20-91</i>		3. TIME OF DEATH M <i>8:02 A</i>			
4. SOCIAL SECURITY NUMBER <i>579-16-3706</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		8. AGE (In yrs. last birthday) <i>75</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>3/15/1915</i>		6. BIRTHPLACE (State or Foreign Country) <i>North Carolina</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Suburban Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Bethesda</i>			9c. COUNTY OF DEATH <i>Montgomery</i>		
10a. STATE <i>District of Columbia</i>		10b. COUNTY <i>Washington</i>		10c. CITY, TOWN OR LOCATION <i>Washington</i>			10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
10e. STREET AND NUMBER <i>868 Yuma Street, S.E.</i>				10f. ZIP CODE <i>20032</i>		10g. CITIZEN OF WHAT COUNTRY? <i>United States</i>			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i>		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i> <i>12th Grade</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Shoe Repairman</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Private</i>					
17. FATHER'S NAME (First, Middle, Last) <i>Frank Smith</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Mattie Baker</i>					
19a. INFORMANT'S NAME (Type/Print) <i>Rita Davis</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>4007 Cleary Court, Mitchellville, MD.</i>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Harmony Memorial Park</i>			20c. LOCATION — City or Town, State <i>Landover, Maryland</i>				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John T. Stewart, III</i>				22. NAME AND ADDRESS OF FACILITY <i>Stewart Funeral Home</i> <i>4001 Benning Rd., N.E. Wash. D.C.</i>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cardiac Arrhythmia</i>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF): <i>Hyper Osmolar Coma</i>  b. DUE TO (OR AS A CONSEQUENCE OF): <i>Diabetes mellitus</i>  c. DUE TO (OR AS A CONSEQUENCE OF):  d. DUE TO (OR AS A CONSEQUENCE OF):  Approximate Interval Between Onset and Death									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Sepsis</i>									
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John Tauber</i>				29c. LICENSE NUMBER <i>20854</i>		29d. DATE SIGNED (Month, Day, Year) <i>2-20-91</i>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>John Tauber</i> <i>8218 W. CONSON AVE</i>									
31. DATE FILED (Month, Day, Year) <i>MAR 05 1991</i>				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randell</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

Released by M.C. Tauber  
DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146  
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 05812

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Nevada Frances DuVal Sollers</b>				2. DATE OF DEATH MONTH DAY YEAR <b>Feb. 26 1991</b>		3. TIME OF DEATH M <b>M</b>	
4. SOCIAL SECURITY NUMBER <b>220-01-2160</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (in yrs. last birthday) <b>76</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Sept. 17 1913</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Carroll Lutheran Village</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Westminster</b>		9c. COUNTY OF DEATH <b>Carroll</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Parkton</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>2201 Mt. Carmel Road</b>				10f. ZIP CODE <b>21120</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Secretary</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Rubber Industry</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Henry Clay DuVal</b>				16. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Lois Rebecca Holcombe</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Duval G. Sollers</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2201 Mt. Carmel Rd., Parkton, Md. 21120</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Lorraine Park Cemetery</b>		20c. LOCATION — City or Town, State <b>Woodlawn, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Martin D. Lawson</i> <b>Martin D. Lawson</b>		22. NAME AND ADDRESS OF FACILITY <b>Lemmon-Mitchell-Wiedefeld Timonium, Maryland 21093</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>cardiogenic Shock</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>CHF</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>ASCVD</b> DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death <b>2d.</b> <b>5yrs</b> <b>5yrs</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 6 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>John M. Leigh</i> <b>John M. Leigh</b>		29c. LICENSE NUMBER <b>D20330</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/26/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>JOHN M. LEIGH, 104 N. Main St., Union Bridge, MD 21091</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 05 1991</b>		32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i> <b>John Davidson-Randall</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 05813

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Joseph J Seeberger Sr.</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>2</b> YEAR <b>91</b>		3. TIME OF DEATH <b>4:20 A M</b>	
4. SOCIAL SECURITY NUMBER <b>213 07 4681</b>		5. SEX <b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs., last birthday) <b>80</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Nov. 20, 1910</b>	
8. BIRTHPLACE (State or Foreign Country) <b>MD.</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Mary Med Center</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Balt MD</b>	
9c. COUNTY OF DEATH <b>Balt City</b>				10a. STATE <b>MD</b>		10b. COUNTY <b>Baltimore</b>	
10c. CITY, TOWN OR LOCATION <b>Balt City</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>438 Margaret Ave.</b>	
10f. ZIP CODE <b>21221</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8th</b> College (1-4 or 5+) <b>Inspector</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Inspector</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Beth Steel</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Michael Seeberger</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Leonard</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Marge Eikenberg</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>206 Charter Oak Place Belair Md. 21014</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Gardens of Faith Cemetery</b>		20c. LOCATION — City or Town, State <b>Rossville Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Connelly Funeral Home</b>				22. NAME AND ADDRESS OF FACILITY <b>ConnellyFuneralHome300MAceAve.21221</b>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>severe COPD</b> b. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Type II diabetes mellitus</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Alfred Schneider MD</b>				29c. LICENSE NUMBER <b>040661</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/2/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>A Schneider 301 St Paul Balt MD 21202</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 05 1991</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				CERTIFICATE OF DEATH				REG. NO.					
1. DECEDENT'S NAME (First, Middle, Last) <i>Ethel - Sibre</i>								2. DATE OF DEATH MONTH <i>3</i> DAY <i>4</i> YEAR <i>91</i>				3. TIME OF DEATH <i>3:15/A</i> M					
4. SOCIAL SECURITY NUMBER <i>214-20-9548</i>				5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>85</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) <i>March 28, 1905</i>		8. BIRTHPLACE (State or Foreign Country) <i>OHIO</i>			
9a. FACILITY NAME (If not institution, give street and number) <i>St. Joseph Hospital</i>								9b. CITY, TOWN OR LOCATION OF DEATH <i>Towson</i>				9c. COUNTY OF DEATH <i>Baltimore</i>					
10a. STATE <i>Md.</i>				10b. COUNTY <i>Baltimore</i>				10c. CITY, TOWN OR LOCATION <i>Glen Arm</i>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER <i>11123 Old Carriage Road</i>								10f. ZIP CODE <i>21057</i>				10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>2nd</i> College (1-4 or 5+) <i>Collega</i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Presser</i>				16b. KIND OF BUSINESS/INDUSTRY									
17. FATHER'S NAME (First, Middle, Last) <i>John Christy</i>								18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Elizabeth ==</i>									
19a. INFORMANT'S NAME (Type/Print) <i>John Sibre</i>								19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>11123 Old Carriage Road Glen Arm Md. 21057</i>									
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Oak Lawn Cemetery</i>				20c. LOCATION — City or Town, State <i>Baltimore Md.</i>									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Connelly Funeral Home</i>								22. NAME AND ADDRESS OF FACILITY <i>Connelly Funeral Home 300 Mace Ave. 21221</i>									
23. PART I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death					
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Aspiration Asphyxia, upper G.T. bleed</i>												<i>30 min</i>					
a. DUE TO (OR AS A CONSEQUENCE OF): <i>Cardiac arrest see to #1</i>																	
b. DUE TO (OR AS A CONSEQUENCE OF): <i>Arteriosclerotic Cardiovascular Dis</i>												<i>10 yrs</i>					
c. DUE TO (OR AS A CONSEQUENCE OF): <i>Silent arrest s/p mechanical implant.</i>												<i>2 yrs</i>					
d. <i></i>																	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)													
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED							
				28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												29b. SIGNATURE AND TITLE OF CERTIFIER <i>SILVINO B. MURRES, M.D., P.A.</i>		29c. LICENSE NUMBER <i>D07309</i>		29d. DATE SIGNED (Month, Day, Year) <i>3/4/91</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>BALTIMORE, MD 21225</i>																	
31. DATE FILED (Month, Day, Year) <i>MAR 05 1991</i>				32. REGISTRAR'S SIGNATURE <i>Jana Davidson-Randell</i>													

2127 NO. D. MINNESOTA, N.D. P.A.  
JAN 19 1961  
BALTIMORE, MD 21201  
(108)

91 05815

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) RITA SZROM				2. DATE OF DEATH MONTH DAY YEAR 02 20 1991				3. TIME OF DEATH 1:45 A M			
4. SOCIAL SECURITY NUMBER 215-28-0241		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 59 YRS.	7. DATE OF BIRTH (Month, Day, Year) 3/25/31		8. BIRTHPLACE (State or Foreign Country) Md.					
9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE			9c. COUNTY OF DEATH BALTIMORE CITY				
RESIDENCE OF DECEDENT											
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Baltimore			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				
10e. STREET AND NUMBER 632 Wilson Avenue				10f. ZIP CODE 21224			10g. CITIZEN OF WHAT COUNTRY? USA				
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: WHITE				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 <sup>th</sup> College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker			16b. KIND OF BUSINESS/INDUSTRY				
17. FATHER'S NAME (First, Middle, Last) John Kuta				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Rolnick							
19a. INFORMANT'S NAME (Type/Print) Sigismund J. Szrom				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 632 Wilson Avenue 21224							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Stanislaus 2/22/91		DATE 2/22/91		20c. LOCATION — City or Town, State Baltimore, Md.					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ Walter G. Dabrowski				22. NAME AND ADDRESS OF FACILITY Walter Dabrowski Funeral Chapel 1005 Dundalk Avenue, Baltimore, Md. 21224							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Carcinomatous Meningitis DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. Gastric Cancer DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 1 week 2 years											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. NONE								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER Samuel J. Gips MD				29c. LICENSE NUMBER			29d. DATE SIGNED (Month, Day, Year) 2/20/91				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Samuel J. Gips MD, Johns Hopkins Hosp, Tower 110, Balto MD 21205											
31. DATE FILED (Month, Day, Year) MAR 05 1991				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05816

1. DECEDENT'S NAME (First, Middle, Last) (AKA) <u>Shirley</u> <u>Stamper</u>				2. DATE OF DEATH MONTH DAY YEAR FEB. 28 1991				3. TIME OF DEATH 145 P M			
4. SOCIAL SECURITY NUMBER <u>216-30-6003</u>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>55</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) APRIL 16, 1935		8. BIRTHPLACE (State or Foreign Country) <u>Maryland</u>			
9a. FACILITY NAME (If not institution, give street and number) <u>Deaton Hospital Medical Center</u>				9b. CITY/TOWN OR LOCATION OF DEATH <u>Baltimore</u>				9c. COUNTY OF DEATH ---			
10a. STATE <u>MD.</u>		10b. COUNTY ---		10c. CITY, TOWN OR LOCATION <u>BALTIMORE</u>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER <u>204 CATHERINE STREET</u>				10f. ZIP CODE <u>21223</u>		10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>U.S.A.</u>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>N/A</u> College (1-4 or 5+) <u>N/A</u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>WAITRESS</u>		16b. KIND OF BUSINESS/INDUSTRY <u>RESTAURANT &amp; BAR</u>							
17. FATHER'S NAME (First, Middle, Last) <u>WALTER HOLLOWAY</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>MARY KUNE</u>							
19a. INFORMANT'S NAME (Type/Print) <u>LINDA BOYER (DGHT)</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1722 DELANEY ST., VIRGINIA BEACH, VA. 23464</u>							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <u>SACRED HEART OF JESUS CEMETERY</u>				20c. LOCATION — City or Town, State <u>BALTIMORE, MD.</u>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>[Signature]</u>				22. NAME AND ADDRESS OF FACILITY <u>SCHIMUNEK FUNERAL HOME INC.</u> <u>3331 Brehms Lane, Baltimore, Md. 21213</u>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Pulmonary Embolus</u> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <u>Lung Cancer</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>Smoking</u> DUE TO (OR AS A CONSEQUENCE OF): d. _____								Approximate Interval Between Onset and Death <u>8 hours</u> <u>3 years</u> <u>40 years</u>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Fractured</u>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide a <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Timothy J. [Signature]</u>						29c. LICENSE NUMBER <u>037458</u>		29d. DATE SIGNED (Month, Day, Year) <u>2/28/91</u>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)											
31. DATE FILED (Month, Day, Year) <u>MAR 05 1991</u>				32. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>							



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH REG. NO.

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) <b>AGNES F. TURNER</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>-1-</b> YEAR <b>91</b>				3. TIME OF DEATH <b>1100 P M</b>							
4. SOCIAL SECURITY NUMBER <b>217-16-7522</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>79</b> YRS.		IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>		7. DATE OF BIRTH (Month, Day, Year) <b>11-7-1911</b>		8. BIRTHPLACE (State or Foreign Country) <b>Md</b>				
9a. FACILITY NAME (If not institution, give street and number) <b>CRURCH HOSPITAL</b>					9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>					9c. COUNTY OF DEATH					
RESIDENCE OF DECEDENT															
10a. STATE <b>MD.</b>		10b. COUNTY			10c. CITY, TOWN OR LOCATION <b>Baltimore</b>					10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
10e. STREET AND NUMBER <b>416 Poplar Grove Street</b>					10f. ZIP CODE <b>21223</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U S A</b>						
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>						
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Seamstress</b>				16b. KIND OF BUSINESS/INDUSTRY							
17. FATHER'S NAME (First, Middle, Last) <b>Hawkins Scriber</b>						18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Kola Scriber</b>									
19a. INFORMANT'S NAME (Type/Print) <b>Agnes Beauford</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>413 Poplar Grove Street Baltimore, Md 21223</b>											
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Cheltenham Veteran Cemetery</b>				20c. LOCATION — City or Town, State <b>Cheltenham, Va</b>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 					22. NAME AND ADDRESS OF FACILITY <b>March F/H West 4300 Wabash Avenue</b>										
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>Adult Respiratory distress syndrome</b> <b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> <b>Pneumonia</b> <b>Sepsis</b>												Approximate interval between Onset and Death <b>7 days</b> <b>3 weeks</b> <b>4 days</b>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>myocardial infarction, ASCVD</b> <b>anemic</b>												24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED							
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28i. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Carol S. Ramsey D.O.</b>						29c. LICENSE NUMBER <b>129212</b>			29d. DATE SIGNED (Month, Day, Year) <b>3-1-91</b>						
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR. RAMSY 100 N. R BROADWAY BALTIMORE MD. 21231</b>															
31. DATE FILED (Month, Day, Year) <b>MAR 05 1991</b>				32. REGISTRAR'S SIGNATURE 											

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**





91 05818

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Abbye Tanzymore				2. DATE OF DEATH MONTH DAY YEAR 2 24 1991		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER 218-09-0906A		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 82 YRS.		7. DATE OF BIRTH (Month, Day, Year) 3-22-1908	
9a. FACILITY NAME (If not institution, give street and number) 900 Argyle Avenue				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH Ga	
10a. STATE Md				10b. COUNTY Baltimore		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 900 Argyle Avenue Apt 10 K				10f. ZIP CODE 21201		10g. CITIZEN OF WHAT COUNTRY? U S A	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY Lutheran Hospital			
17. FATHER'S NAME (First, Middle, Last) William Tanzymore				18. MOTHER'S NAME (First, Middle, Maiden Surname) Zimmie			
19a. INFORMANT'S NAME (Type/Print) Willoris Miller				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Apt 10 K 900 Argyle Avenue Baltimore, Md 21201			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Western Star Cemetery 3191		20c. LOCATION — City or Town, State Catonsville, Md			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John March</i>				22. NAME AND ADDRESS OF FACILITY March F/H West 4300 Wabash Avenue			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Heart Failure</u> DUE TO (OR AS A CONSEQUENCE OF):  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Alzheimers disease; h/o cerebral vascular acc-</u> <u>idents &amp; multi-infarct dementia; h/o full cardio-</u> <u>pulm. arrest; h/o G-I. bleed; h/o hypertension.</u>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined		26a. DATE OF INJURY (Month, Day, Year)		26b. TIME OF INJURY M		26c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		26d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Thomas J. Regan MD</i>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) 2/26/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Thomas J. Regan, MD, Univ. of Maryland Hospital, Dept. of Medicine							
31. DATE FILED (Month, Day, Year) MAR 05 1991		32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 26 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 05819

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>HOWARD THOMAS</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>1</b> YEAR <b>91</b>		3. TIME OF DEATH <b>10 10 A M</b>	
4. SOCIAL SECURITY NUMBER <b>219-01-1002</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		8. AGE (In yrs. last birthday) <b>74</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>June 5, 1916</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>St. Agnes Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>3600 West Franklin Street Apt. 2K</b>				10f. ZIP CODE <b>21229</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Or divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>Oct '42 to Feb '43</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Longshoreman</b>		16b. KIND OF BUSINESS/INDUSTRY <b>ILA-STA</b>			
17. FATHER'S NAME (First, Middle, Last) <b>William Thomas</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Bertha Heburn</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Eva Thomas</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21229</b> <b>3600 West Franklin Street Apt 2K Balto., MD</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Garrison Forest Veteran Cem.</b>		20c. LOCATION — City or Town, State <b>Owings Mills, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Barry L. Rollins</b>				22. NAME AND ADDRESS OF FACILITY <b>Nutter Funeral Homes, Inc.</b> <b>2501 Gwynns Fall Parkway</b> <b>Baltimore, Maryland 21216</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Pneumonia, possible Sepsis</b> a. DUE TO (OR AS A CONSEQUENCE OF):  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Clara D. Miller, MD</b>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>3-1-91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>CHOL, WAN</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 05 1991</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

OHMH-16 Rev 1/89

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.**



TO THE HOSPITAL DRAUGHTING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				CERTIFICATE OF DEATH				REG. NO.											
1. DECEDENT'S NAME (First, Middle, Last) <b>Clifton Thomas</b>								2. DATE OF DEATH (Month, Day, Year) <b>2 24 91</b>				3. TIME OF DEATH <b>20:00 M</b>											
4. SOCIAL SECURITY NUMBER <b>213-32-3952</b>				5. AGE (In yrs. last birthday) <b>55 YRS.</b>		6. IF UNDER 1 YEAR		7. DATE OF BIRTH (Month, Day, Year) <b>4-28-35</b>		8. BIRTHPLACE (State or Foreign Country) <b>Virginia</b>													
9a. FACILITY NAME (If not institution, give street and number) <b>St. Agnes Hospital</b>								9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>				9c. COUNTY OF DEATH											
10a. STATE <b>Maryland</b>				10b. COUNTY				10c. CITY, TOWN OR LOCATION <b>Baltimore City</b>				10d. INSIDE CITY LIMITS? <b>1 X YES 2 NO</b>											
10e. STREET AND NUMBER <b>333 Harlem Lane</b>								10f. ZIP CODE <b>21228</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>											
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>											
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Disability</b>				16b. KIND OF BUSINESS/INDUSTRY															
17. FATHER'S NAME (First, Middle, Last) <b>Thomas</b>								18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Jessie Allen</b>															
19a. INFORMANT'S NAME (Type/Print) <b>Jessie Thomas</b>								19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>302 South Vincent Street Balto., MD. 21223</b>															
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Loudon Park Cemetery</b>				20c. LOCATION — City or Town, State <b>Balto., MD.</b>															
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Dorothy Spector #281</b>				22. NAME AND ADDRESS OF FACILITY <b>E.L. Phillips F/H 1721-27 N. Monroe Balto., MD. 21217</b>																			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Septic Shock. + CVA + Acidosis</b>  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <div style="display: flex; align-items: center;"> <div style="font-size: 4em; margin-right: 10px;">{</div> <div> <p>a. <b>Overwhelming Sepsis + ASCD.</b></p> <p>b. <b>UTI.</b></p> <p>c. <b>Chronic Indwelling Catheter, b/c + CVA</b></p> </div> </div>												Approximate Interval Between Onset and Death											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY <b>M</b>				28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO											
				28d. DESCRIBE HOW INJURY OCCURRED																			
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)															
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												29b. SIGNATURE AND TITLE OF CERTIFIER <b>Medical Resident</b>				29c. LICENSE NUMBER				29d. DATE SIGNED (Month, Day, Year)			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dusy Limig, 900 Catm Av. Balto MD 21229.</b>																							
31. DATE FILED (Month, Day, Year) <b>MAR 05 1991</b>				32. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>																			





91 05822

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>RAYMOND ARLE WILSON</b>				2. DATE OF DEATH MONTH <b>2</b> DAY <b>23</b> YEAR <b>91</b>		3. TIME OF DEATH <b>10 10A</b> M	
4. SOCIAL SECURITY NUMBER <b>578-28-3389</b>		5. SEX <b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>62</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>5/30/28</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>HOLY CROSS HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>SILVER SPRINGS</b>		9c. COUNTY OF DEATH <b>MONTGOMERY</b>	
10a. STATE <b>DC</b>				10b. COUNTY <b>WASHINGTON</b>		10d. INSIDE CITY LIMITS? <b>1</b> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>3800 V ST. SE #101</b>				10f. ZIP CODE <b>20020</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <b>1</b> <input type="checkbox"/> Never Married <b>2</b> <input checked="" type="checkbox"/> Married <b>3</b> <input type="checkbox"/> Widowed <b>4</b> <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>1950-1953</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th Grade</b> College (1-4 or 6+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Draftsman</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Government</b>	
17. FATHER'S NAME (First, Middle, Last) <b>William H. Wilson, Sr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Matilda H. Neal</b>			
19a. INFORMANT'S NAME (Type/Print) <b>William Wilson</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3249 O Street, S.E. Wash. D.C.</b>			
20a. METHOD OF DISPOSITION <b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State <b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Ft. Lincoln Cemetery</b>		DATE <b>Brentwood, MD.</b>		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>John T. Stewart, III</b>				22. NAME AND ADDRESS OF FACILITY <b>Stewart Funeral Home</b> <b>4001 Benning Road, N.E. Wash. D.C.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Respiratory Failure</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. Metastatic Lung Cancer</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>c.</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b>							Approximate Interval Between Onset and Death <b>1 week</b> <b>6 months</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>24a. WAS AN AUTOPSY PERFORMED?</b> <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO <b>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?</b> <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1</b> <input checked="" type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA OTHER: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation <b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined <b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Douglas Van Zeeven, MD</b>				29c. LICENSE NUMBER <b>DC 15632</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/23/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Douglas Van Zeeven, MD</b> <b>1011 N. Capitol, NE Wash DC</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 05 1991</b>		32. REGISTRAR'S SIGNATURE <b>Gina Davidson-Rendell</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>John Paul Willard</b>				2. DATE OF DEATH MONTH DAY YEAR <b>3 3 91</b>		3. TIME OF DEATH <b>3:45 P. M.</b>	
4. SOCIAL SECURITY NUMBER <b>227-18-7663</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>84</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>7-28-1906</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Inns of Evergreen Nursing Home</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>		9c. COUNTY OF DEATH	
10a. STATE <b>Md.</b>				10b. COUNTY <b>- - -</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore City</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>301 S. East Ave. Highlandtown</b>			
10f. ZIP CODE <b>21224</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>unknown</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Brakeman</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Canton Railroad</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Allen Crockett Willard</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Carrie May Ward</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Arlene F. Kintzel</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>301 S. East Ave., Baltimore, Md. 21224</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Oaklawn Cemetary</b>		20c. LOCATION — City or Town, State <b>Baltimore, MD.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Moran-Ashton Funeral Home, Inc. 3000 E. Baltimore St/Balto. MD 21224</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acute Myelocytic Leukemia</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):						Approximate interval Between Onset and Death <b>Months</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>S/P Adenocarcinoma of the Colon</b>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D00426</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/4/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) <b>MAR 05 1991</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 05824

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <b>MATTHEW WILLIAMS</b>		2. DATE OF DEATH MONTH <b>3</b> DAY <b>1</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>0400 A</b>
4. SOCIAL SECURITY NUMBER <b>216-20-9875</b>	5. SEX <b>1</b> M <b>2</b> F	6. AGE (In yrs. last birthday) <b>63</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>July 2, 1927</b>
8. BIRTHPLACE (State or Foreign Country) <b>South Carolina</b>		9a. FACILITY NAME (If not institution, give street and number) <b>University Hospital</b>		
9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH		
RESIDENCE OF DECEASED				
10a. STATE <b>Maryland</b>	10b. COUNTY	10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? <b>1</b> YES <b>2</b> NO
10e. STREET AND NUMBER <b>1802 North Carey Street</b>		10f. ZIP CODE <b>21217</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
11. MARITAL STATUS <b>1</b> Never Married <b>2</b> Married <b>3</b> Widowed <b>4</b> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <b>1</b> YES <b>2</b> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> YES <b>2</b> NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>		15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>College (1-4 or 5+)</b>		
16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Tractor Driver</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Bethlehem Steel</b>		
17. FATHER'S NAME (First, Middle, Last) <b>Melvin Williams</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Shannon</b>		
19a. INFORMANT'S NAME (Type/Print) <b>Deborah McCullum</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1802 North Carey Street Baltimore, MD 21207</b>		
20a. METHOD OF DISPOSITION <b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Arbutus Memorial Park</b>		20c. LOCATION — City or Town, State <b>Baltimore County, MD</b>
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Veronica Bailey</i>		22. NAME AND ADDRESS OF FACILITY <b>Nutter Funeral Homes, Inc. 2501 Gwynns Falls Parkway Baltimore, Maryland 21216</b>		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Ventricular Arrhythmia</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Respiratory Failure</b> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { <b>Ant. Septal Myocardial Infarction</b> DUE TO (OR AS A CONSEQUENCE OF):				Approximate Interval Between Onset and Death <b>30 mins</b> <b>1 hour</b> <b>2/3/91</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypertension</b>				24a. WAS AN AUTOPSY PERFORMED? <b>1</b> YES <b>2</b> NO <b>To be done</b>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> YES <b>2</b> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1</b> YES <b>2</b> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA OTHER: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify)		27. MANNER OF DEATH <b>1</b> Natural <b>2</b> Accident <b>3</b> Suicide <b>4</b> Homicide <b>5</b> Pending Investigation <b>6</b> Could not be determined		
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	28c. INJURY AT WORK? <b>1</b> YES <b>2</b> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER (Check only one) <b>1</b> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. SIGNATURE AND TITLE OF CERTIFIER <b>G.B. Aiello M.D.</b>		29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>3/1/91</b>
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DAVID AIELLO UNIV. OF MD Hosp. 22 S. Greene St</b>				
31. DATE FILED (Month, Day, Year) <b>MAR 05 1991</b>		32. REGISTRAR'S SIGNATURE <i>Guth Davidson-Randall</i>		

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH				3. TIME OF DEATH			
Anna L. Waldd				MARCH 2 1991				11:30 A M			
4. SOCIAL SECURITY NUMBER		5. SEX		6. AGE (In yrs. last birthday)		7. DATE OF BIRTH		8. BIRTHPLACE (State or Foreign Country)			
212-12-4996		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		86 YRS.		Feb. 2, 1905		Md.			
9a. FACILITY NAME (If not institution, give street and number)				9b. CITY, TOWN OR LOCATION OF DEATH				9c. COUNTY OF DEATH			
Levindale Hospital				Baltimore				City			
10a. STATE				10b. COUNTY				10c. CITY, TOWN OR LOCATION			
Md.								Baltimore			
10d. INSIDE CITY LIMITS?				10e. STREET AND NUMBER				10f. ZIP CODE			
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				5525 Hillen Road				21239			
10g. CITIZEN OF WHAT COUNTRY?				11. MARITAL STATUS				12. WAS DECEDENT EVER IN U.S. ARMED FORCES?			
USA				1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)				14. RACE — American Indian, Black, White, etc.				15. DECEDENT'S EDUCATION (Specify only highest grade completed)			
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				White				Elementary/Secondary (0-12) College (1-4 or 5+)			
15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16. KIND OF BUSINESS/INDUSTRY				17. FATHER'S NAME (First, Middle, Last)			
Homemaker								Julius Ende			
18. MOTHER'S NAME (First, Middle, Maiden Surname)				19a. INFORMANT'S NAME (Type/Print)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
				Joseph G. Waldd				5525 Hillen Road Baltimore, Md. 21239			
20a. METHOD OF DISPOSITION				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)				20c. LOCATION — City or Town, State			
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				Most Holy Redeemer 3/5/91				Baltimore, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE				22. NAME AND ADDRESS OF FACILITY				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.			
James J. Bladden				Leonard J. Ruck Inc. 5305 Harford Rd. 21214				IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MULTIPLE INFECTED DECUBITI DUE TO (OR AS A CONSEQUENCE OF):			
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST				b. DUE TO (OR AS A CONSEQUENCE OF):				Approximate Interval Between Onset and Death			
c. DUE TO (OR AS A CONSEQUENCE OF):				d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED?				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
				1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER?				26. PLACE OF DEATH (Check only one)				27. MANNER OF DEATH			
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY				28c. INJURY AT WORK?			
				M				1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one)				29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUMBER			
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				Cecilia O. Kw, M.D.				217037			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)				31. DATE FILED (Month, Day, Year)				32. REGISTRAR'S SIGNATURE			
ESTRELLITA O. Kw, M.D. - LEVINDALE HEBREW GERIATRIC CENTER & HOSPITAL				MAR 05 1991				Julia Davidson			

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				91 05826	
CERTIFICATE OF DEATH				REG. NO.					
1. DECEDENT'S NAME (First, Middle, Last) <b>Ida Mae Wilson</b>				2. DATE OF DEATH MONTH DAY YEAR <b>2 28 91</b>				3. TIME OF DEATH <b>9<sup>30</sup> PM</b>	
4. SOCIAL SECURITY NUMBER <b>251-60-0443</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>63</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>8/31/27</b>		8. BIRTHPLACE (State or Foreign Country) <b>S. Carolina</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Union Memorial Extended Care Unit</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>				9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT									
10a. STATE <b>MD SC</b>		10b. COUNTY <b>Richland</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore Columbia</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>606 Cator Ave.</b>				10f. ZIP CODE <b>21218</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>N/A</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Registered Nurse</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Hospital</b>					
17. FATHER'S NAME (First, Middle, Last) <b>Lonnie Myers</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Ida Mae Gordon</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Geraldine Brown</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>606 Cator Ave., Baltimore, MD 21218</b>					
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Temple Zion Baptist Ch. Cem.</b>		20c. LOCATION — City or Town, State <b>Columbia, SC</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>R. George Attish</i>				22. NAME AND ADDRESS OF FACILITY <b>ROBERT C. ALTENBURG FUNERAL HOME, INC. 6009 Harford Rd., Baltimore, MD 21214</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Respiratory arrest</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>b. chronic renal failure</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c. seizure disorder</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d. diabetes</b>								Approximate interval between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)	
28b. TIME OF INJURY <b>M</b>				28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29b. SIGNATURE AND TITLE OF CERTIFIER <i>June E. Breiner MD</i>	
29c. LICENSE NUMBER <b>D40208</b>				29d. DATE SIGNED (Month, Day, Year) <b>3/1/91</b>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>June E. Breiner 600 W Northern Pkway Balto Md 21210</b>									
31. DATE FILED (Month, Day, Year) <b>3/1/91</b>				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>					



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05827

1. DECEDENT'S NAME (First, Middle, Last) Mary C. Ayers				2. DATE OF DEATH MONTH DAY YEAR 03 02 1991		3. TIME OF DEATH M					
4. SOCIAL SECURITY NUMBER 216 24 9306		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) 85 YRS.		7. DATE OF BIRTH (Month, Day, Year) 10-7-1905		8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not institution, give street and number) Anne Arundel General Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Annapolis			9c. COUNTY OF DEATH Anne Arundel				
RESIDENCE OF DECEDENT											
10a. STATE Maryland		10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 412 Fairfax Avenue				10f. ZIP CODE 21225		10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 7th Grade College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		16b. KIND OF BUSINESS/INDUSTRY Home Maker					
17. FATHER'S NAME (First, Middle, Last) Urise Watson				18. MOTHER'S NAME (First, Middle, Maiden Surname) Cecilia (Unknown)							
19a. INFORMANT'S NAME (Type/Print) James Dunphy				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 412 Fairfax Avenue Baltimore, Maryland 21225							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Meadowridge Memorial Park		20c. LOCATION — City or Town, State Baltimore, Maryland							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George J. Gonce</i>				22. NAME AND ADDRESS OF FACILITY George J. Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive Heart failure DUE TO (OR AS A CONSEQUENCE OF): b. Pneumonia DUE TO (OR AS A CONSEQUENCE OF): c. Gram Negative Septicemia DUE TO (OR AS A CONSEQUENCE OF): d. Ischemic cardiomyopathy Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John P. Serlento</i>				29c. LICENSE NUMBER 032654		29d. DATE SIGNED (Month, Day, Year) 3/4/91					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John P. Serlento 180 Admiral Cochrane Drive, Annapolis, MD											
31. DATE FILED MAR 06 1991				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>							



91-1166-510

91 05828

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Brandon D. Butler				2. DATE OF DEATH MONTH 03 DAY 02 YEAR 1991		3. TIME OF DEATH 10:23 A M		
4. SOCIAL SECURITY NUMBER 220-29-7786		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) YRS. 5		7. DATE OF BIRTH (Month, Day, Year) 10-24-90		8. BIRTHPLACE (State or Foreign Country) MD	
9a. FACILITY NAME (If not institution, give street and number) Johns Hopkins Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City		9c. COUNTY OF DEATH		
RESIDENCE OF DECEDENT								
10a. STATE MD		10b. COUNTY		10c. CITY, TOWN OR LOCATION BALTIMORE, CITY		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		
10e. STREET AND NUMBER 4525 CLAREWAY				10f. ZIP CODE 21213		10g. CITIZEN OF WHAT COUNTRY? USA		
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) CHILD College (1-4 or 5+) CHILD				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CHILD		16b. KIND OF BUSINESS/INDUSTRY		
17. FATHER'S NAME (First, Middle, Last) VINCENT BUTLER				18. MOTHER'S NAME (First, Middle, Maiden Surname) TASHELLA CLACK				
19a. INFORMANT'S NAME (Type/Print) DARLENE BOONE				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4525 CLAREWAY / BALTIMORE, MD. 21213				
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) WESTERN STAR CEMETERY		20c. LOCATION — City or Town, State CATONSVILLE, MD		20d. DATE		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Bladys Wane				22. NAME AND ADDRESS OF FACILITY WM.C. MARCH F.H. 1101 E. NORTH AVE.				
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sudden Infant Death Syndrome DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):								
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) 03 02 1991		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) A.M. DIXON 111 Penn Street, Baltimore Maryland 21201								
31. DATE FILED (Month, Day, Year) MAR 6 1991				32. REGISTRAR'S SIGNATURE Julia Davidson				

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 05829

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>GLORIA BROWN</b>		2. DATE OF DEATH MONTH <b>3</b> DAY <b>2</b> YEAR <b>91</b>		3. TIME OF DEATH <b>10:15 P M</b>
4. SOCIAL SECURITY NUMBER <b>219-40-9749</b>	5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>47</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>05--2-43</b>	8. BIRTHPLACE (State or Foreign Country) <b>MD</b>
9a. FACILITY NAME (If not institution, give street and number) <b>UNIVERSITY HOSPITAL</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE, MD</b>		9c. COUNTY OF DEATH
RESIDENCE OF DECEDENT				
10a. STATE <b>MD</b>	10b. COUNTY	10c. CITY, TOWN OR LOCATION <b>BALTIMORE, CITY</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
10e. STREET AND NUMBER <b>2112 JEFFERSON STREET</b>		10f. ZIP CODE <b>21205</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>ASSEMBLY</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last) <b>JAMES WILLIAMS</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>OLLIE MAE ANDERSON</b>		
19a. INFORMANT'S NAME (Type/Print) <b>LILLIE ROBBINS</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1435 E. EAGER ST./BALTIMORE, MD. 21205</b>		
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>BALTIMORE CEMETERY</b>		20c. LOCATION — City or Town, State <b>BALTIMORE, MD.</b>
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Bladine W...</i>		22. NAME AND ADDRESS OF FACILITY <b>WM.C. MARCH F.H. 1101 E. NORTH AVE.</b>		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. RESPIRATORY ARREST</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>b. METASTATIC SQUAMOUS CELL CARCINOMA</b> DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d. Approximate Interval Between Onset and Death				
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY <b>M</b>	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
		28d. DESCRIBE NOW INJURY OCCURRED		29. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Michael D. ... MD</i>		
		29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>3/2/91</b>
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>UNIVERSITY OF MARYLAND HOSPITAL 22 So. GREENE ST, BALTIMORE, MD 21201</b>				
31. DATE FILED (Month, Day, Year) <b>MAR 6 1991</b>		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>		

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05830

1. DECEDENT'S NAME (First, Middle, Last) <b>Stanley E. Block</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>4</b> YEAR <b>91</b>		3. TIME OF DEATH M			
4. SOCIAL SECURITY NUMBER <b>219-03-6367</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>70</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>2-3-20</b>		8. BIRTHPLACE (State or Foreign Country) <b>MD.</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>1413 Pleasant Valley Dr.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Catonsville</b>			9c. COUNTY OF DEATH <b>Baltimore Co.</b>		
10a. STATE <b>MD.</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Catonsville</b>			10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER <b>1413 Pleasant Valley Dr. - Balto., MD.</b>				10f. ZIP CODE <b>21228</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: <b>N/A</b>			14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>N/A</b> College (1-4 or 5+) <b>N/A</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Engineering Man</b>			16b. KIND OF BUSINESS/INDUSTRY <b>Westinghouse</b>				
17. FATHER'S NAME (First, Middle, Last) <b>Charles E. Block</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Helen Morley</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Carolyn A. Block</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1413 Pleasant Valley Dr. - Balto., MD. 21228</b>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Lakeview Cemetery</b>		20c. LOCATION — City or Town, State <b>Sykesville, MD.</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>G. Truman Schwab</b>				22. NAME AND ADDRESS OF FACILITY <b>5151 Baltimore National Pike Baltimore, MD. 21229</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. METASTATIC COLON CARCINOMA</b> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): <b>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b>								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>[Signature]</b>		29c. LICENSE NUMBER <b>019419</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/4/91</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DANNA H. CORIFFER 900 CATON AVE. BALTO. MD. 21229</b>									
31. DATE FILED (Month, Day, Year) <b>MAR 6 1991</b>						32. REGISTRAR'S SIGNATURE <b>[Signature]</b>			



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH REG. NO.

REG. NO.

91 05831

1. DECEDENT'S NAME (First, Middle, Last) <b>Brockington Kathryn (NMN) Brockington</b>				2. DATE OF DEATH MONTH <b>March</b> DAY <b>1</b> YEAR <b>1991</b> TIME <b>1745 PM</b>					
4. SOCIAL SECURITY NUMBER <b>217-52-9194</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>39</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>07-28-51</b>		8. BIRTHPLACE (State or Foreign Country) <b>Balto.Md</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>University of Maryland</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>				9c. COUNTY OF DEATH <b>City</b>	
10a. STATE <b>Md</b>				10b. COUNTY <b>Baltimore</b>				10c. CITY, TOWN OR LOCATION <b>Baltimore</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>1707 Bentalou St</b>				10f. ZIP CODE <b>21216</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>US</b>				11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>12</b>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>clerk</b>				16b. KIND OF BUSINESS/INDUSTRY				17. FATHER'S NAME (First, Middle, Last) <b>Isaac Brockington</b>	
18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Esther Fowlkes</b>				19a. INFORMANT'S NAME (Type/Print) <b>Esther Brockington</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1707 Bentalou St Baltimore,md</b>	
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Western Star</b>				20c. LOCATION — City or Town, State <b>Balto. county</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>M.Tellington Funeral Directors Inc. 814 Upshur St. N.W. Washington DC</b>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Pseudomonas Sepsis</b>  Sequitentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  <b>HIV infection</b>	
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) <input checked="" type="checkbox"/> Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) <b>3/1/91</b>	
28b. TIME OF INJURY <b>5:45 PM</b>				28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Rose Bright MD</b>				29c. LICENSE NUMBER				29d. DATE SIGNED (Month, Day, Year) <b>3/1/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Rose Bright</b>				31. DATE FILED (Month, Day, Year) <b>MAR 06 1991</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



91 05832

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Magiline Ellalouise Ballard</b>						2. DATE OF DEATH MONTH DAY YEAR <b>FEBRUARY 28 1991</b>		3. TIME OF DEATH HOUR MIN <b>7:40 A M</b>	
4. SOCIAL SECURITY NUMBER <b>217-32-0736</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>62</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>May 27, 1928</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>DOCTORS COMMUNITY HOSPITAL</b>						9b. CITY, TOWN OR LOCATION OF DEATH <b>LANHAM</b>		9c. COUNTY OF DEATH <b>PRINCE GEORGE</b>	
RESIDENCE OF DECEDENT									
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Prince George's</b>		10c. CITY, TOWN OR LOCATION <b>Bowie</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER <b>7910 Chestnut Avenue</b>						10f. ZIP CODE <b>20715</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Building Supervisor</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Government</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Augustine Carter</b>						18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Pearl Barber</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Calvin D. Ballard</b>						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7910 Chestnut Avenue; Bowie, MD. 20715</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Ft. Lincoln Cemetery 3-4-91</b>		20c. LOCATION — City or Town, State <b>Bladensburg, Maryland</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Joseph B. Jenkins Jr.</b>						22. NAME AND ADDRESS OF FACILITY <b>J. B. Jenkins Funeral Home 7474 Landover Road; Landover, Maryland</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CHRONIC RESPIRATORY DYSMET</b>  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  b. <b>CHRONIC MYOCARDIAL INFARCT</b> c. <b>CONVULSION ANTERIOR DISSECT</b> d. <b>CONVULSION ANTERIOR DISSECT</b>								Approximate Interval Between Onset and Death <b>1 hour</b> <b>1 yr</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HYPERTENSION</b> <b>DIABETES MELLITUS</b>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO								26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <b>John M. [Signature]</b>						29c. LICENSE NUMBER <b>06197</b>		29d. DATE SIGNED (Month, Day, Year) <b>3-1-91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>A. C. LANA, MD, 9326 LAMAR-SONSH RD, LAMAR MD</b>									
31. DATE FILED (Month, Day, Year) <b>MAR 06 1991</b>				32. REGISTRAR'S SIGNATURE <b>John Davidson-Pondell</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10

FOX RIVER

1000

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05833

1. DECEDENT'S NAME (First, Middle, Last) <u>Rachel Billings</u>				2. DATE OF DEATH MONTH DAY YEAR <u>March 5, 1991</u>				3. TIME OF DEATH <u>9:45 A.M.</u>	
4. SOCIAL SECURITY NUMBER <u>214-48-6611</u>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>45</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>October 22, 45</u>		8. BIRTHPLACE (State or Foreign Country) <u>Maryland</u>	
9a. FACILITY NAME (If not institution, give street and number) <u>9120 Dandelion Lane</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>Upper Marlboro, Md.</u>				9c. COUNTY OF DEATH <u>Prince George</u>	
10a. STATE <u>Md.</u>		10b. COUNTY <u>Prince George</u>		10c. CITY, TOWN OR LOCATION <u>Upper Marlboro, Maryland</u>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <u>9120 Dandelion Lane</u>				10f. ZIP CODE <u>20772</u>		10g. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <u>Black</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12th</u> College (14 or 16+) <u>College</u>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Nurse</u>				16b. KIND OF BUSINESS/INDUSTRY <u>Private</u>	
17. FATHER'S NAME (First, Middle, Last) <u>Neeland Wesley Queen</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Gladys R. Shorter</u>					
19a. INFORMANT'S NAME (Type/Print) <u>Darius Billings (Son)</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>9120 Dandelion Lane; Upper Marlboro, MD. 20772</u>					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Resurrection Cemetery</u>				20c. LOCATION — City or Town, State <u>Clinton, Maryland</u>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Jimmy C. Neal</u>				22. NAME AND ADDRESS OF FACILITY <u>J. B. Jenkins Funeral Home</u> <u>7474 Landover Road; Landover, MD 20785</u>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>1. METASTATIC RENAL CELL CANCER</u> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death <u>1.5 YRS</u>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u></u>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <u></u>		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <u></u>		28d. DESCRIBE HOW INJURY OCCURRED <u></u>							
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <u></u>									
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Stephen P. Stahl M.D.</u>				29c. LICENSE NUMBER <u>D18219</u>		29d. DATE SIGNED (Month, Day, Year) <u>3/5/91</u>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>STEPHEN P. STAHL 8300 CORPORATE DR. LANDOVER MD 20785</u>									
31. DATE FILED (Month, Day, Year) <u>MAR 06 1991</u>				32. REGISTRAR'S SIGNATURE <u>Jana Davidson-Randall</u>					





ITEM:4 per FH  
G-673 3/6/91 cm

91 05834

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JACQUELINE Breighner</b>		2. DATE OF DEATH MONTH DAY YEAR <b>02 25 91</b>		3. TIME OF DEATH <b>10:45A M</b>	
4. SOCIAL SECURITY NUMBER <b>159-58-8048</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) <b>29</b> YRS.	
6. DATE OF BIRTH (Month, Day, Year) <b>10-29-61</b>		7. BIRTHPLACE (State or Foreign Country) <b>PENNSYLVANIA</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>UMMS</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore, MD</b>		9c. COUNTY OF DEATH <b>21201</b>	
10a. STATE <b>PA</b>		10b. COUNTY <b>YORK</b>		10c. CITY, TOWN OR LOCATION <b>RRB Box 14 YORK PA</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>RRB 14</b>		10f. ZIP CODE <b>17403-0000</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b></b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOME MAKER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>DOMESTIC</b>	
17. FATHER'S NAME (First, Middle, Last) <b>JACK E. FAHS</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>DARLENE V. SHAW</b>			
19a. INFORMANT'S NAME (Type/Print) <b>STEVEN RAY BREIGNER</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>R.D. #8 BOX 14 INDIAN ROCK DAM ROAD YORK, PA. 17403</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>YORKTOWNE CASKETS INC.</b>		20c. LOCATION — City or Town, State <b>YORK, PENNSYLVANIA</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>David E. Small</b>		22. NAME AND ADDRESS OF FACILITY <b>DAVID E. SMALL FUNERAL HOME INC. 471 MADISON AVENUE YORK, PENNSYLVANIA 17404</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cerebral ischemia</b>  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF): <b>intracerebral aneurysm rupture → SAM</b>  b. DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d. DUE TO (OR AS A CONSEQUENCE OF):  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypertension</b>					
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>Home</b>		28b. TIME OF INJURY M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED <b>ruptured aneurysm</b>		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>Home</b>	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>22 Sequoia St Bkfst. Md</b>					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Ken E. Small MD</b>		29c. LICENSE NUMBER <b>AN 4120435AS2134</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/25/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Ken E. Small MD</b>					
31. DATE FILED (Month, Day, Year) <b>2 MAR 06 91</b>		32. REGISTRAR'S SIGNATURE <b>John Davidson</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 05835

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JAMES BLAKENEY, JR.</b>				2. DATE OF DEATH MONTH DAY YEAR <b>FEB 16 1991</b>		3. TIME OF DEATH HOURS MINUTES P M <b>9:07 P</b>	
4. SOCIAL SECURITY NUMBER <b>250-30-4954</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>65</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>OCT 12 1925</b>	
8. BIRTHPLACE (State or Foreign Country) <b>SOUTH CAROLINA</b>				9a. FACILITY NAME (If not institution, give street and number) <b>NATIONAL NAVAL MEDICAL CENTER</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BETHESDA</b>	
9c. COUNTY OF DEATH <b>MONTGOMERY</b>				10a. STATE <b>DISTRICT OF COLUMBIA</b>		10b. COUNTY <b>DISTRICT OF COLUMBIA</b>	
10c. CITY, TOWN OR LOCATION <b>DISTRICT OF COLUMBIA</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>1424 TAYLOR STREET, NW</b>	
10f. ZIP CODE <b>20011</b>				10g. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>U.S. NAVY</b>		16b. KIND OF BUSINESS/INDUSTRY <b>DEFENSE</b>	
17. FATHER'S NAME (First, Middle, Last) <b>JAMES BLAKENEY</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>NELLIE THOMAS</b>			
19a. INFORMANT'S NAME (Type/Print) <b>VERONICA HUGHES</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>337 RANDOLPH STREET, NW, WASHINGTON, DC 20011</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Foundry Hill Cemetery</b>		20c. LOCATION — City or Town, State <b>Cheraw, South Carolina</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Cheraw S.C.</i>				22. NAME AND ADDRESS OF FACILITY <b>284 Second Street</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>e. METASTATIC SQUAMOUS CELL CARCINOMA COMPLICATED BY PULMONARY EMBOLISM</b>  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>R. W. Hargrave MD</i>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>2/19/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>R. W. HARGRAVES, CDR, MC, USN</b>				31. DATE FILED (Month, Day, Year) <b>MAR 06 '91</b>			
32. REGISTRAR'S SIGNATURE <i>John A. ...</i>				33. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>NATIONAL NAVAL MEDICAL CENTER BETHESDA, MD 20889-5000</b>			

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



91 05836

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MARGARET LOUISE BOBBITT</b>				2. DATE OF DEATH MONTH DAY YEAR <b>FEBRUARY 20, 1991</b>		3. TIME OF DEATH <b>2:20 AM</b>	
4. SOCIAL SECURITY NUMBER <b>229-14-1475</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>72</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Dec. 6, 1918</b>	
8. BIRTHPLACE (State or Foreign Country) <b>NORTH CAROLINA</b>				9a. FACILITY NAME (If not institution, give street and number) <b>PHYSICIANS MEMORIAL HOSPITAL</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>LA PLATA</b>	
9c. COUNTY OF DEATH <b>CHARLES</b>				10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>CHARLES</b>	
10c. CITY, TOWN OR LOCATION <b>LA PLATA</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER	
10f. ZIP CODE <b>20646</b>				10g. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>CAUCASIAN</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+) <b>HOMEMAKER</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOMEMAKER</b>		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <b>JOHN ARTHUR LOVE</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>VEANNIE VIRGINIA LINER</b>			
19a. INFORMANT'S NAME (Type/Print) <b>LINDA J. McGLOCKIN</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>ROUTE 1, BOX 700, BURKEVILLE, VA 23922</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>CREWE CEMETERY</b>		20c. LOCATION — City or Town, State <b>CREWE, VIRGINIA</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <i>C.L. Jennings Funeral Home</i> <i>Chesapeake, VA</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Sudden Pneumonia</i>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <i>Acromegaly</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Diabetes Mellitus</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE NOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>D-20629</b>		29d. DATE SIGNED (Month, Day, Year) <b>Feb. 20, 1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>WATHEN, GEORGE H, M, D, PEMBROOKE SQUARE, #104 HIGHWAY 301 SOUTH MD, 20603</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 06 '91</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.



DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				REG. NO.	
CERTIFICATE OF DEATH							
1. DECEDENT'S NAME (First, Middle, Last) JOHN C. CLARK, JR.				2. DATE OF DEATH MONTH 03 DAY 02 YEAR 91		3. TIME OF DEATH 4:55 P M	
4. SOCIAL SECURITY NUMBER 212-52-5832		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 39 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 5, 1951	
8. BIRTHPLACE (State or Foreign Country) Maryland							
9a. FACILITY NAME (If not institution, give street and number) NORTH ARUNDEL HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE MD.		9c. COUNTY OF DEATH ANNE ARUNDEL	
10a. STATE Maryland				10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Pasadena	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 7612 Second Street				10f. ZIP CODE 21122		10g. CITIZEN OF WHAT COUNTRY? U.S.	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Salesman		16b. KIND OF BUSINESS/INDUSTRY Brush Company			
17. FATHER'S NAME (First, Middle, Last) John C. Clark, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Madeline Kiley			
19a. INFORMANT'S NAME (Type/Print) Marlene Wojciechowski				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 515 Yawl Dr., Ocean City, MD 21842			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory		DATE 3/4/91		20c. LOCATION — City or Town, State Baltimore Co., Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George J. Gonce</i>				22. NAME AND ADDRESS OF FACILITY George J. Gonce Funeral Home, P.A. 4001 Ritchie Hgwy., Baltimore, Md. 21225			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) →  Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. <i>Non-Hodgkin's Lymphoma</i> DUE TO (OR AS A CONSEQUENCE OF):  b. <i>Acquired Immunodeficiency Syndrome</i> DUE TO (OR AS A CONSEQUENCE OF):  c. _____ DUE TO (OR AS A CONSEQUENCE OF):  d. _____				Approximate interval Between Onset and Death 3 months			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____ _____				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Carl Friedman</i>				29c. LICENSE NUMBER D 20688		29d. DATE SIGNED (Month, Day, Year) 3/4/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. CARL FRIEDMAN 660 KENILWORTH DR. TOWSON, MD. 21204							
31. DATE FILED (Month, Day, Year) MAR 06 1991				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randell</i>			





91 05838

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>LARRY ORLANDO COFER</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>4</b> YEAR <b>91</b>		3. TIME OF DEATH <b>7:4</b> M	
4. SOCIAL SECURITY NUMBER <b>229-84-6465</b>		5. SEX <b>1</b> M <b>2</b> F		6. AGE (In yrs. last birthday) <b>34</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>7-11-56</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>2704 UPSHUR STREET #1</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>MT. RANIER</b>		9c. COUNTY OF DEATH <b>PRINCE GEORGE</b>	
10a. STATE <b>MD</b>		10b. COUNTY <b>PRINCE GEORGE</b>		10c. CITY, TOWN OR LOCATION <b>MT. RANIER</b>		10d. INSIDE CITY LIMITS? <b>1</b> YES <b>2</b> NO	
10e. STREET AND NUMBER <b>2704 UPSHUR STREET</b>				10f. ZIP CODE <b>20712</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <b>1</b> Never Married <b>2</b> Married <b>3</b> Widowed <b>4</b> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> YES <b>2</b> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> YES <b>2</b> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 Yrs</b> College (1-4 or 5+) <b>4 Yrs</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housekeeper</b>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>Unknown</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary E Cofer</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mary E Curtis</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>210 Henry St., Bluefield, W. Va 24701</b>			
20a. METHOD OF DISPOSITION <b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>6</b> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Cofer Family Cemetery</b>		20c. LOCATION — City or Town, State <b>Montvale, Va</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Juan Smith</b>				22. NAME AND ADDRESS OF FACILITY <b>John T Rhines Co., Inc 3015 12th St NE, DC 20017</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ACQUIRED IMMUNODEFICIENCY SYNDROME</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death <b>years</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <b>1</b> YES <b>2</b> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1</b> YES <b>2</b> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> YES <b>2</b> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA OTHER: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify)					
27. MANNER OF DEATH <b>1</b> Natural <b>6</b> Pending Investigation <b>2</b> Accident <b>6</b> Could not be determined <b>3</b> Suicide <b>4</b> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>N/A</b>		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1</b> YES <b>2</b> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29. CERTIFIER (Check only one) <b>1</b> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29a. SIGNATURE AND TITLE OF CERTIFIER <b>Deputy Medical Examiner</b>				29b. LICENSE NUMBER <b>201852</b>		29c. DATE SIGNED (Month, Day, Year) <b>3-4-91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Paul A. DeLore MD, 9203 Greensburg Rd Hyattsville MD 20781</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 06 1991</b>				32. REGISTRAR'S SIGNATURE <b>John R. Henderson</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

6

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

IF THIS HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

20% COTTON FIBRE

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05839

1. DECEDENT'S NAME (First, Middle, Last) <b>GRACIE CHEATHAM</b>				2. DATE OF DEATH MONTH <b>03</b> DAY <b>02</b> YEAR <b>91</b>		3. TIME OF DEATH <b>8:00 PM</b>			
4. SOCIAL SECURITY NUMBER <b>233 22 0296</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>91</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>12/15/1898</b>		8. BIRTHPLACE (State or Foreign Country) <b>VIRGINIA</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Sinai Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Balt.</b>				9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT									
10a. STATE <b>Maryland</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>503 GLEN ALLEN DRIVE</b>				10f. ZIP CODE <b>21223</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>BENJAMIN CHEATHAM</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>EVIE CHEATHAM</b>					
19a. INFORMANT'S NAME (Type/Print) <b>ROBERT CHEATHAM</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>MYRTLE CLAYBORNE 3323 BELLE AVENUE: BALTIMORE, MD 21215</b>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>ARBUTUS MEMORIAL PARK</b>		20c. LOCATION — City or Town, State <b>ARBUTUS, MARYLAND</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Leroy O. Dyett</i>				22. NAME AND ADDRESS OF FACILITY <b>LEROY O. DYETT &amp; SON FUNERAL HOME 4600 LIBERTY HEIGHTS AVENUE</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Sudden Renal failure - Uremia</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. <b>Ventricular arrhythmia - refractory</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>Drug therapy</b> DUE TO (OR AS A CONSEQUENCE OF): d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hyper tension</b>								Approximate interval Between Onset and Death	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Adnan S. Adawi M.D.</i>				29c. LICENSE NUMBER <b>9006</b>	
29d. DATE SIGNED (Month, Day, Year) <b>3/2/91</b>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>ADNAN S. ADAMI Sinai Hospital of Baltimore.</b>					
31. DATE FILED (Month, Day, Year) <b>MAR 06 1991</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05840

1. DECEDENT'S NAME (First, Middle, Last) <b>Ralph Campbell</b>				2. DATE OF DEATH MONTH <b>2</b> DAY <b>27</b> YEAR <b>91</b>		3. TIME OF DEATH <b>2:05 PM</b>	
4. SOCIAL SECURITY NUMBER <b>219-90-4602</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>78</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>2-1-1913</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>WATERVIEW HealthCare Center</b>				8b. CITY, TOWN OR LOCATION OF DEATH <b>Salisbury</b>		8c. COUNTY OF DEATH <b>Wicomico</b>	
9. RESIDENCE OF DECEDENT							
10a. STATE <b>md</b>		10b. COUNTY <b>Wicomico</b>		10c. CITY, TOWN OR LOCATION <b>Salisbury</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>105 Times Square</b>				10f. ZIP CODE <b>21801</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)			
19a. INFORMANT'S NAME (Type/Print) <b>MsJackson Social Worker</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Tawes-Bland Bryant Spring Grove Stae Hospital</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Other (Specify) <b>in state</b>		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Ronald Wade, Dir</b> <b>3/5/91</b>				22. NAME AND ADDRESS OF FACILITY <b>STATE ANATOMY BOARD</b> <b>655 W. Baltimore St, Balto. MD 21201</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Fine disease or condition resulting in death) → <b>a. CHF. (congestive heart failure)</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>b. ASCVD</b> DUE TO (OR AS A CONSEQUENCE OF):  <b>c.</b> DUE TO (OR AS A CONSEQUENCE OF):  <b>d.</b>							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>pneumonia</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Jefferson</b>				29c. LICENSE NUMBER <b>D29105</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/28/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) <b>MAR 6 1991</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



ITEM:4 per FH  
G-673 3/14/91 cm  
91-1139-033

91 05841

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Joseph Frank Chillemi				2. DATE OF DEATH MONTH DAY YEAR 02 28 1991		3. TIME OF DEATH 9:45 A M			
4. SOCIAL SECURITY NUMBER 145-32-5637 <del>145-32-5673</del>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 48 YRS.		7. DATE OF BIRTH (Month, Day, Year) Dec. 18, 1942		8. BIRTHPLACE (State or Foreign Country) New Jersey	
9a. FACILITY NAME (If not institution, give street and number) Doctor's Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Lanham			9c. COUNTY OF DEATH Prince Georges		
10a. STATE Maryland		10b. COUNTY Prince Georges		10c. CITY, TOWN OR LOCATION Lanham			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER 6803--97th Place				10f. ZIP CODE 20807		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Mailer			16b. KIND OF BUSINESS/INDUSTRY Washington Post				
17. FATHER'S NAME (First, Middle, Last) Frank P. Chillemi				18. MOTHER'S NAME (First, Middle, Maiden Surname) Helen Bruno					
19a. INFORMANT'S NAME (Type/Print) Leo Chillemi				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 303 Arcadian Circle SW Vienna, Virginia 22180					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Geo. Washington Mem'l Park 3/4/		DATE 3/4/		20c. LOCATION — City or Town, State Paramus, New Jersey			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ernest L. Myers</i>				22. NAME AND ADDRESS OF FACILITY Money & King Funeral Home, Inc. 171 W. Maple Ave. Vienna, Virginia					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Chronic liver</i> b. <i>chronic alcoholism</i> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { c. d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide 4 <input type="checkbox"/>		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Mario F. Golub, Jr. MD</i>				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) 03 01 1991			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARIO F. GOLUB, JR. MD 111 Penn Street, Baltimore, Maryland 21201									
31. DATE FILED (Month, Day, Year) MAR 06 1991				32. REGISTRAR'S SIGNATURE <i>John L. ...</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

THE NEW YORK PUBLIC LIBRARY

ASTOR LENOX TILDEN FOUNDATION



91 05842

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>GREENE, CHARLIE</b>				2. DATE OF DEATH MONTH DAY YEAR <b>03/03/91</b>		3. TIME OF DEATH <b>12.40AM</b>	
4. SOCIAL SECURITY NUMBER <b>251-38-2007</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>61</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>8/15/29</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>PRINCE GEORGES HOSP. CENTER</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>CHEVERLY</b>		9c. COUNTY OF DEATH <b>PRINCE GEORGE</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Prince George's</b>		10c. CITY, TOWN OR LOCATION <b>Glenarden</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>7917 Johnson Avee</b>			
10f. ZIP CODE <b>20785</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Maintenance Engineer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Private</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Ed Green</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Pressley</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Eric J. Green</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1941 NW 46th Ave #H/Lauder Hill, Fla. 33313</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Harmony Memorial Park</b>		20c. LOCATION — City or Town, State <b>Landover, Md</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James C. Neal Sr.</i>				22. NAME AND ADDRESS OF FACILITY <b>J.B. Jenkins Funeral Home 7474 Landover Rd/Landover, Md 20785</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>cardiac arrest</b> a. DUE TO (OR AS A CONSEQUENCE OF): <b>cardiogenic shock</b> b. DUE TO (OR AS A CONSEQUENCE OF): <b>ischemic cardiomyopathy</b> c. DUE TO (OR AS A CONSEQUENCE OF): <b>coronary artery disease</b> d. SEQUENTIALLY LIST CONDITIONS, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>paroxysmal atrial fibrillation, acute myocardial infarction, hyperlipidemia, anxiety, encephalopathy</b>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. Douglas MD</i>				29c. LICENSE NUMBER <b>D24270</b>		29d. DATE SIGNED (Month, Day, Year) <b>3-3-91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. RAVIN DOR K. REESTAGI 6132 Landover Rd Cheverly Md 20785</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 06 1991</b>				32. REGISTRAR'S SIGNATURE <i>John Davidson</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE FUNERAL DIRECTOR: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				CERTIFICATE OF DEATH		REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last) <b>Erma M. Dingle</b>						2. DATE OF DEATH MONTH <b>3</b> DAY <b>4</b> YEAR <b>91</b>		3. TIME OF DEATH <b>2:40 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>215-03-2144</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>80</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>9-1-10</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Franklin Square Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Rossville</b>			9c. COUNTY OF DEATH <b>Baltimore</b>		
10a. STATE <b>Maryland</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Baltimore City</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>4313 Belmar Avenue</b>				10f. ZIP CODE <b>21206</b>			10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>8th grade</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Mortgage Dept.</b>			16b. KIND OF BUSINESS/INDUSTRY <b>1st National Bank</b>		
17. FATHER'S NAME (First, Middle, Last) <b>George Albert Dingle</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Christina M. Grau</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Mrs. Kathryn Dellone</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2 Councilman Avenue Baltimore, Maryland 21206</b>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Most Holy Redeemer Cemetery</b>			20c. LOCATION — City or Town, State <b>Baltimore, Maryland</b>				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Lassahn Funeral Home</b>				22. NAME AND ADDRESS OF FACILITY <b>Lassahn Funeral Home</b> <b>7401 Belair Rd. Balto., Md. 21236</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Sudden Myocardial Infarction</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <b>Advanced Atherosclerosis with CHD and Renal Failure</b>								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Sudden myocardial infarction</b>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>Michael A. Hyle</b>		29c. LICENSE NUMBER <b>D27693</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/5/91</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Michael A. Hyle 7527 Belair Rd. Balto., Md. 21236 (665-0595)</b>									
31. DATE FILED (Month, Day, Year) <b>MAR 06 1991</b>				32. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>					



91 05844

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MELVIN L. DURGIN				2. DATE OF DEATH MONTH 3 DAY 3 YEAR 91		3. TIME OF DEATH 11:20 p. M				
4. SOCIAL SECURITY NUMBER 215-03-4544		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 76 YRS.		7. DATE OF BIRTH (Month, Day, Year) 7/18/14		8. BIRTHPLACE (State or Foreign Country) MARYLAND		
9a. FACILITY NAME (If not institution, give street and number) V.A. MEDICAL CNTR., FT. HOWARD, MD.				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE			9c. COUNTY OF DEATH BALTIMORE			
10a. STATE MARYLAND			10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION BALTIMORE - CARNEL			10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER 9714 OAK SUMMIT AVE.				10f. ZIP CODE 21234		10g. CITIZEN OF WHAT COUNTRY? U.S.A.				
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WORLD WAR II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 YRS.		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Oil Burner		16b. KIND OF BUSINESS/INDUSTRY B.P. Oil Refinery						
17. FATHER'S NAME (First, Middle, Last) William Durgin				18. MOTHER'S NAME (First, Middle, Maiden Surname) Cecelia Collins						
19a. INFORMANT'S NAME (Type/Print) CLINICAL RECORDS				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9600 NORTH POINT ROAD, FORT HOWARD, MD 21052						
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) PARKWOOD CEMETERY		20c. LOCATION — City or Town, State PARKVILLE, MARYLAND						
21. SIGNATURE OF FUNERAL SERVICE LICENSEE [Signature]		22. NAME AND ADDRESS OF FACILITY EVANS CHAPEL OF MEMORIES 8800 HARFORD ROAD - PARKVILLE								
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Atherosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus, Glaucoma							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER Marcia Kane MD				29c. LICENSE NUMBER D26391		29d. DATE SIGNED (Month, Day, Year) 3/4/91				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARCIA KANE, M.D., 9600 NORTH POINT ROAD, FORT HOWARD, MARYLAND 21052										
31. DATE FILED (Month, Day, Year) MAR 06 1991		32. REGISTRAR'S SIGNATURE [Signature]								



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05845

1. DECEDENT'S NAME (First, Middle, Last) <b>HELEN ELLIOTT</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>2</b> YEAR <b>91</b>		3. TIME OF DEATH <b>6:40 P M</b>					
4. SOCIAL SECURITY NUMBER <b>217 05 6098</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>86</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>9-11-1904</b>		8. BIRTHPLACE (State or Foreign Country) <b>Virginia</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>North Arundel Convalescent Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Glen Burnie</b>				9c. COUNTY OF DEATH <b>Anne Arundel</b>			
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Anne Arundel</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER <b>5500 Park Road</b>				10f. ZIP CODE <b>21225</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 8th Grade</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Home Maker</b>							
17. FATHER'S NAME (First, Middle, Last) <b>Charles Temple Allen</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Annie Brower Martin</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Jean Ritchie</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2900 Rayshire Road Baltimore, Maryland 21230</b>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Cedar Hill Cemetery</b>			20c. LOCATION — City or Town, State <b>Baltimore, Maryland</b>						
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donna M. Brumirewski</i>				22. NAME AND ADDRESS OF FACILITY <b>George J. Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Metastatic Carcinoma of Colon</b> DUE TO (OR AS A CONSEQUENCE OF): a. <b>arteriosclerotic Cardiovascular disease</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>Chronic Congestive Heart Failure</b> DUE TO (OR AS A CONSEQUENCE OF): d. <b>Senile Dementia</b> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>arteriosclerosis</b>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Mustafa Cam Durs</i>						29c. LICENSE NUMBER <b>D 22206</b>		29d. DATE SIGNED (Month, Day, Year) <b>3 3 91</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)											
31. DATE FILED (Month, Day, Year) <b>MAR 06 1991</b>				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>							





91 05846

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) LUELLE Price Evitt				2. DATE OF DEATH MONTH DAY YEAR Feb 22, 1991		3. TIME OF DEATH 5:15 PM M	
4. SOCIAL SECURITY NUMBER 250 42 5437		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 86 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept 12, 1904	
8. BIRTHPLACE (State or Foreign Country) South Carolina				9a. FACILITY NAME (If not institution, give street and number) 1329 Chippendale Road		9b. CITY, TOWN OR LOCATION OF DEATH Lutherville	
9c. COUNTY OF DEATH Baltimore Co				10a. STATE MD		10b. COUNTY Balto Co	
10c. CITY, TOWN OR LOCATION Lutherville				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 1329 Chippendale Road	
10f. ZIP CODE 21093				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES NO				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: NO			
14. RACE — American Indian, Black, White, etc. Specify: White				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 + College (1-4 or 5+) 4			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Retired				16b. KIND OF BUSINESS/INDUSTRY teacher/homemaker			
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname) Price			
19a. INFORMANT'S NAME (Type/Print) Dorothy Hemphill LegalGardian				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Atty Sherwood Hackett 344W PatrickSt, Frederick, MD 29581			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)			
20c. LOCATION — City or Town, State				21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald S. Wade, Dir 2/25/91			
22. NAME AND ADDRESS OF FACILITY State Anatomy Board 655 W. Baltimore St, Balto., MD 21201				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Cardiac Arrest</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>Myocardial Infarction</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>Renal Failure</u> DUE TO (OR AS A CONSEQUENCE OF): d. <u>Hypertension</u> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M			
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE NOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER Frank Morris			
29c. LICENSE NUMBER D18406				29d. DATE SIGNED (Month, Day, Year) 2-20-91			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Frank Morris 341 North Calvert Street, Baltimore, MD 21202							
31. DATE FILED (Month, Day, Year) MAR 6 1991				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital, attending physician, or funeral director. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be filed with the State Dept. of Health and Mental Hygiene as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05847

1. DECEDENT'S NAME (First, Middle, Last) <b>Dorothy Alberta Flowers</b>		2. DATE OF DEATH MONTH DAY YEAR <b>February 14, 1991</b>		3. TIME OF DEATH <b>AM</b>	
4. SOCIAL SECURITY NUMBER		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>59 YRS.</b>	
7. DATE OF BIRTH (Month, Day, Year) <b>Sept. 4, 1931</b>		8. BIRTHPLACE (State or Foreign Country) <b>West Virginia</b>		9. COUNTY OF DEATH <b>Washington</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>14450 Rice Road</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Hancock</b>		9c. COUNTY OF DEATH <b>Washington</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Washington</b>		10c. CITY, TOWN OR LOCATION <b>Hancock</b>	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>14450 Rice Road</b>		10f. ZIP CODE <b>21750</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5</b> College (1-4 or 6+) <b>Homemaker</b>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY		17. FATHER'S NAME (First, Middle, Last) <b>Ivan Unger</b>	
18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Icy Shaw</b>		19a. INFORMANT'S NAME (Type/Print) <b>Charles W. Flowers</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>14450 Rice Road Hancock, Maryland 21750</b>	
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Mt. Olivet Presby. Cemetery</b>		20c. LOCATION — City or Town, State <b>Hancock, Md. 21750</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY <b>Grove Funeral Home</b> <b>141 W. Main Street Hancock, Md. 21750</b>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Bronchogenic Carcinoma</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):	
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <b>28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO</b> <b>28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO</b> <b>28d. DESCRIBE HOW INJURY OCCURRED</b> <b>28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)</b> <b>28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)</b>	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER <b>D21457</b>	
29d. DATE SIGNED (Month, Day, Year) <b>2/27/91</b>		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>ABDUL WAHED MD - 1610 Oak Hill Ave. Hagerstown MD 21740</b>		31. DATE FILED (Month, Day, Year) <b>MAR 06 1991</b>	
32. REGISTRAR'S SIGNATURE 					



91 05848

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>HAROLD W. FREEMAN</b>				2. DATE OF DEATH MONTH DAY YEAR <b>FEB. 28, 1991</b>		3. TIME OF DEATH A. M. <b>M</b>	
4. SOCIAL SECURITY NUMBER <b>188 05 5014</b>		5. SEX <b>1 M 2 F</b>		6. AGE (In yrs. last birthday) <b>71</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>OCT. 11, 1919</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Pennsylvania</b>							
9a. FACILITY NAME (If not institution, give street and number) <b>17 CAVAN DRIVE</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>LUTHERVILLE</b>		9c. COUNTY OF DEATH <b>BALTIMORE</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>BALTIMORE</b>		10c. CITY, TOWN OR LOCATION <b>LUTHERVILLE</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>17 CAVAN DRIVE</b>				10f. ZIP CODE <b>21093</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>W.W.II</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 YRS.</b> College (1-4 or 5+) <b>8 YRS.</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>SCHOOL TEACHER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>BALTIMORE COUNTY</b>	
17. FATHER'S NAME (First, Middle, Last) <b>William Freeman</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Annie Kimmel</b>			
19a. INFORMANT'S NAME (Type/Print) <b>FAMILY RECORDS</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>SAME AS ABOVE</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>GREEN MOUNT CREMATORY 3/1</b>		DATE <b>3/1</b>		20c. LOCATION — City or Town, State <b>BALTO., MD.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>EVANS CHAPEL OF CHIMES 2325 YORK ROAD - TIMONUM</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>METASTATIC ADENOCARCINOMA OF LIVER</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)					
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>031207</b>		29d. DATE SIGNED (Month, Day, Year) <b>FEB. 28, 1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DAVID SAUTZBERG MD 660 KENIL WORTH DRIVE TOWSON MD 21204</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 06 1991</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05849

1. DECEDENT'S NAME (First, Middle, Last) <b>MAURICE M. GUERRASIO</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>3</b> YEAR <b>91</b>		3. TIME OF DEATH <b>12:05 a M</b>					
4. SOCIAL SECURITY NUMBER <b>215-24-9499</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>62</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>3-15-28</b>		8. BIRTHPLACE (State or Foreign Country) <b>Md.</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>614 Longview Drive</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Catonsville</b>				9c. COUNTY OF DEATH <b>Baltimore Co.</b>			
10a. STATE <b>Md.</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Catonsville</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER <b>614 Longview Dr. - Baltimore, Md.</b>				10f. ZIP CODE <b>21228</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>Yes</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: <b>N/A</b>		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>N/A</b> College (1-4 or 5+) <b>N/A</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Policeman</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Baltimore City</b>							
17. FATHER'S NAME (First, Middle, Last) <b>Michael A. Guerrasio</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Genevieve Doering</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Betty J. Guerrasio</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>614 Longview Dr. - Catonsville, Md. 21228</b>							
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metro Crematory, Inc.</b>		20c. LOCATION — City or Town, State <b>Baltimore, Md.</b>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>G. Truman Schwab</b>				22. NAME AND ADDRESS OF FACILITY <b>5151 Baltimore National Pike Baltimore, Md. 21229</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Lung Cancer</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 6 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Wm. C. Waterfield MD</b>						29c. LICENSE NUMBER <b>024356</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/4/91</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Wm. C. Waterfield MD St Agnes Hospital 900 Caton Ave Balt 21229</b>											
31. DATE FILED (Month, Day, Year) <b>MAR 6 1991</b>				32. REGISTRAR'S SIGNATURE <b>J. Davidson</b>							





REG. NO.

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**



91 05851

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Mary P. GOODMAN</b>				2. DATE OF DEATH MONTH DAY YEAR <b>3 3 1991</b>		3. TIME OF DEATH <b>8:25 a.m.</b>	
4. SOCIAL SECURITY NUMBER <b>212-10-8870</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>79</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>2-5-12</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Franklin Square Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Rossville</b>		9c. COUNTY OF DEATH <b>Baltimore County</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>White Marsh</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>11203 Beach Rd.</b>				10f. ZIP CODE <b>21162</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>3rd grade</b>		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Homemaking</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Joseph Pavone</b>				16. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Olivia Carbone</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mr. Lloyd L. Goodman</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11203 Beach Rd. White Marsh, Md. 21162</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Lake View Memorial Park</b>		DATE		20c. LOCATION — City or Town, State <b>Baltimore, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Lassahn Funeral Home</b>				22. NAME AND ADDRESS OF FACILITY <b>Lassahn Funeral Home 7401 Belair Rd. Balto., Md. 21236</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Aspiration Pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Lobar Pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Congestive Heart Failure</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>John Loh, M.D.</b>				29c. LICENSE NUMBER <b>H35593</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/3/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>John Loh, M.D. 9000 Franklin Square Drive Baltimore 21237</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 06 1991</b>				32. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BOARD

SMITH BOARD

91 05852

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>ARNOLD LeRoy Golden</u>				2. DATE OF DEATH MONTH <u>2</u> DAY <u>22</u> YEAR <u>91</u>		3. TIME OF DEATH <u>9:25</u> AM	
4. SOCIAL SECURITY NUMBER <u>205-09-0136</u>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>86</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>Jan. 7, 1905</u>	
9a. FACILITY NAME (If not institution, give street and number) <u>Garlock Nursing Home</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>Hagerstown</u>		9c. COUNTY OF DEATH <u>Washington</u>	
RESIDENCE OF DECEDENT							
10a. STATE <u>Maryland</u>		10b. COUNTY <u>Washington</u>		10c. CITY, TOWN OR LOCATION <u>Hagerstown</u>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <u>241 S. Prospect Street</u>				10f. ZIP CODE <u>21740</u>		10g. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>Unknown</u> College (1-4 or 5+) <u></u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Truck Driver</u>		16b. KIND OF BUSINESS/INDUSTRY <u>Hauling</u>			
17. FATHER'S NAME (First, Middle, Last) <u>Roy C. Golden</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Anna Bowers</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Louise M. Golden</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>206 E. Terrace Hancock, Maryland 21750</u>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Sphors Cross Roads Cemetery</u>		20c. LOCATION — City or Town, State <u>Berkeley Springs, WVa.</u>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>[Signature]</u>				22. NAME AND ADDRESS OF FACILITY <u>Grove Funeral Home</u> <u>141 West Main Street Hancock, Md. 21750</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Pneumonia</u> Sequitely flat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death <u>1 week</u>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>UTI, pneumonia, severe O/S</u>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>[Signature]</u>				29c. LICENSE NUMBER <u>D18019</u>		29d. DATE SIGNED (Month, Day, Year) <u>2-22-91</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>VASANT DATTA, MD 334 MILL ST HAGERSTOWN, MD 21740</u>							
31. DATE FILED (Month, Day, Year) <u>MAR 06 1991</u>		32. REGISTRAR'S SIGNATURE <u>[Signature]</u>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 05853

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MORRIS LOUIS GARMISE</b> <i>Morris Garmise</i>				2. DATE OF DEATH MONTH DAY YEAR <b>3 3 91</b>		3. TIME OF DEATH <b>3:10 AM</b>	
4. SOCIAL SECURITY NUMBER <b>029 07 5656</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>83</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>April 13, 1907</b>	
9a. FACILITY NAME (If not institution, give street and number) <i>Manor Core Potomac</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Potomac Md</i>		9c. COUNTY OF DEATH <i>Montgomery</i>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Rockville</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1801 E. Jefferson Street</b>				10f. ZIP CODE <b>20852</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>4</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Merch</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Self-employed</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Isaac Garmise</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Bessie Borowitz</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Carolyn Garmise</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5305 Westpath Way Bethesda, Md. 20816</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Lakeview Cemetery</b>		20c. LOCATION — City or Town, State <b>Ithaca, NY</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Caputo</i>				22. NAME AND ADDRESS OF FACILITY <b>Ives-Pearson Funeral Homes Falls Church, Va. 22046</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Coronary Artery Disease s/p CABG</b> 1/23/91 DUE TO (OR AS A CONSEQUENCE OF): a. <b>Aortic Stenosis with aortic valvulopathy</b> 1/23/91 DUE TO (OR AS A CONSEQUENCE OF): c. <b>Congestive Heart Failure</b> years DUE TO (OR AS A CONSEQUENCE OF): d. <b>Peripheral Vascular Disease</b> years Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Donna Lina MD</i>				29c. LICENSE NUMBER <b>D28135</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/3/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>D Lina's MD, 11510 OLD GEORGETOWN RD, ROCKVILLE</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 06 1991</b>		32. REGISTRAR'S SIGNATURE <i>Lilia Davidson-Randall</i> <b>MD 20852</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

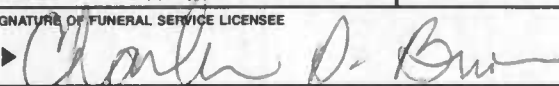
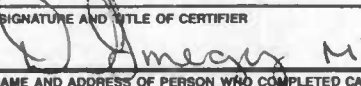
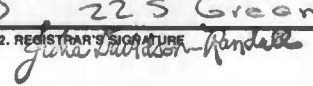




91 05854

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Romell Greene</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>1</b> YEAR <b>91</b>		3. TIME OF DEATH <b>9:55 P M</b>	
4. SOCIAL SECURITY NUMBER		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>84</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) <b>12-15-06</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>University of MD Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH <b>Baltimore City</b>	
10a. STATE <b>MD</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>503 S. Paca St.</b>				10f. ZIP CODE <b>21230</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— if yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Factory Worker</b>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>William Williams</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Lugenia Chisolm</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Eugene Myles</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>503 S. Paca St., Baltimore, MD. 21230</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Carver Memorial Park</b>		20c. LOCATION — City or Town, State <b>Laurel, MD.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Joseph H. Brown Jr. P.A. 1913 W. Baltimore St. 21223</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.						Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Myocardial Ventricular arrhythmia</b>						<b>12 hrs</b>	
DUE TO (OR AS A CONSEQUENCE OF): <b>Myocardial infarction</b>						<b>8 days</b>	
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER  <b>D. Greene MD</b>		29c. LICENSE NUMBER <b>D40707</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/1/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>D. Greene MD 225 Greene St. Balt., MD 21201</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 06 1991</b>		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91-1223-510

91 05855

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Anthony E. Hardaway</b>				2. DATE OF DEATH MONTH DAY YEAR <b>03 04 1991</b>		3. TIME OF DEATH <b>7:53 P M</b>	
4. SOCIAL SECURITY NUMBER <b>212-84-4227</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>27</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>10-31-63</b>	
8. FACILITY NAME (If not institution, give street and number) <b>Rear of 502 S. Chapelgate Road</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>		9c. COUNTY OF DEATH <b>MD.</b>	
10a. STATE <b>Md.</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>5830 Leithwalk Rd.</b>				10f. ZIP CODE <b>21239</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>11th</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Unemployed</b>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>William A. Hardaway</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Alternease Leak</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Alternease Hardaway</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3604 Bowers Ave. Apt. C Balto., Md. 21215</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Arbutus 3-6-91</b>		DATE <b>Arbutus, Md.</b>		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Derrick C. Jones</i>				22. NAME AND ADDRESS OF FACILITY <b>Derrick C. Jones F.H. 4611 Park Heights Ave. Balto., Md. 21215</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>GUNSHOT WOUNDS OF HEAD</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>03 04 1991</b>		28b. TIME OF INJURY <b>7:40 P</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED <b>Subject shot</b>		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>Street</b>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>Rear of 502 S. Chapelgate Rd</b>			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>A. M. Dixon</i>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>03 05 1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>A. M. Dixon 111 Penn Street, Baltimore, Maryland 21201</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 06 1991</b>		32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Wm. J. Linscott

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Michael D. Hedges</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>4</b> YEAR <b>91</b>		3. TIME OF DEATH <b>4:55 P M</b>	
4. SOCIAL SECURITY NUMBER <b>None</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) YRS. <b>2</b> MONTHS <b>1</b> DAYS <b>1</b> HOURS <b>1</b> MIN.		7. DATE OF BIRTH (Month, Day, Year) <b>1-3-91</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Md.</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Sinai Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>	
9c. COUNTY OF DEATH <b>Baltimore City</b>				10a. STATE <b>Md.</b>			
10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Woodlawn</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>2001 Oak Drive-Baltimore, Md.</b>	
10f. ZIP CODE <b>21207</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input checked="" type="checkbox"/> N/A <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: <b>N/A</b>		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>N/A</b> College (1-4 or 5+) <b>N/A</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>N/A</b>	
16b. KIND OF BUSINESS/INDUSTRY <b>N/A</b>		17. FATHER'S NAME (First, Middle, Last) <b>James L. Hedges</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Margaret D. Dove</b>		19a. INFORMANT'S NAME (Type/Print) <b>James L. Hedges</b>	
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2001 Oak Drive-Baltimore, Md. 21207</b>		20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Cedar Hill Cemetery</b>		20c. LOCATION — City or Town, State <b>Baltimore, Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>G. Truman Schwab</b>		22. NAME AND ADDRESS OF FACILITY <b>5151 Baltimore National Pike Baltimore, Md. 21229</b>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Sudden Infant Death Syndrome</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   				24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Other		28a. DATE OF INJURY (Month, Day, Year) <b>28b. TIME OF INJURY M</b> <b>28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO</b> <b>28d. DESCRIBE HOW INJURY OCCURRED</b> <b>28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)</b> <b>28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)</b>	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>A. M. Dixon</b>		29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>3-5-91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>A. M. Dixon</b>				31. DATE FILED (Month, Day, Year) <b>MAR 6 1991</b>			
32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>				33. DATE OF DEATH <b>111 Penn St. Baltimore Md.</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 05857

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Herman J. Henderson</i>				2. DATE OF DEATH MONTH <i>3</i> DAY <i>5</i> YEAR <i>91</i>		3. TIME OF DEATH <i>3:00 A.</i> M	
4. SOCIAL SECURITY NUMBER <i>212-09-7064</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs., last birthday) <i>83</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>07 03 07</i>	
8. BIRTHPLACE (State or Foreign Country) <i>Md.</i>				9a. FACILITY NAME (If not institution, give street and number) <i>Francis Scott Key Medical Center</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore City</i>	
9c. COUNTY OF DEATH <i>Md.</i>				10a. STATE <i>Md.</i>		10b. COUNTY <i>Baltimore</i>	
10c. CITY, TOWN OR LOCATION <i>Baltimore</i>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <i>148 South Highland Avenue</i>	
10f. ZIP CODE <i>21224</i>				10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <i>W.W. 2</i>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>?</i> College (1-4 or 5+) <i>?</i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Maintenance</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Distillery</i>	
17. FATHER'S NAME (First, Middle, Last) <i>John Henderson</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Theresa Seebauer</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Ann Henderson</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>148 S. Highland Ave. Balto., Md. 21224</i>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Green Mount Crematory 3-6-91</i>		20c. LOCATION — City or Town, State <i>Balto., Md.</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Charles D. Zeiler</i>				22. NAME AND ADDRESS OF FACILITY <i>Charles S. Zeiler &amp; Son Inc. 901 S. Conkling St.</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. <i>Cardiac Dysrhythmia - Bradycardia</i>							
DUE TO (OR AS A CONSEQUENCE OF):							
b. <i>Coronary Artery Disease</i>							
DUE TO (OR AS A CONSEQUENCE OF):							
c. <i>Hypertension</i>							
DUE TO (OR AS A CONSEQUENCE OF):							
d. <i>Renal Failure</i>							
Approximate Interval Between Onset and Death <i>1 day</i> <i>years</i> <i>days</i> <i>days</i>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Chronic Obstructive Pulmonary Disease</i>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>A. B. Davidson MD</i>				29c. LICENSE NUMBER <i>D40394</i>		29d. DATE SIGNED (Month, Day, Year) <i>3/5/91</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>A. B. Davidson MD</i>							
31. DATE FILED (Month, Day, Year) <i>3/5/MAR 06 1991</i>				32. REGISTRAR'S SIGNATURE <i>G. Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>GEORGE HARRIS</b>				2. DATE OF DEATH MONTH <b>03</b> DAY <b>04</b> YEAR <b>91</b>		3. TIME OF DEATH <b>10:03 A<sup>M</sup></b>	
4. SOCIAL SECURITY NUMBER <b>220 12 8697</b>		5. SEX <b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>65</b> YRS.		7. DATE OF BIRTH <b>1/15/26</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>3511 WINDSOR MILL ROAD</b>				8b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>		8c. COUNTY OF DEATH	
10a. STATE <b>Md.</b>				10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
10e. STREET AND NUMBER <b>3511 Windsor Mill Rd/</b>				10f. ZIP CODE <b>21216</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WWII 51--56</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Shipyard-PLANT</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Steel</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Arthur Harris</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Chaney Hicks</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Georgia Renee King</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2123 Ashburton St. Balto., Md. 21216</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>King Mem. Park</b>		DATE		20c. LOCATION — City or Town, State <b>Balto., Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James A. Morton</i>				22. NAME AND ADDRESS OF FACILITY <b>James A. Morton &amp; Sons</b> <b>1701 Laurens St. Balto., Md. 21217</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>congestive heart failure</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):							Approximate interval between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic Alcoholism</b>							24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>A.M. Dixon</i>		29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>03/05/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>A.M. Dixon 111 PENN STREET, BALTIMORE, MARYLAND 21201</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 6 1991</b>		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Pendall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 05859

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Herman J. Hamlett</b>				2. DATE OF DEATH MONTH DAY YEAR <b>3-5-91</b>		3. TIME OF DEATH <b>4:00A</b>	
4. SOCIAL SECURITY NUMBER <b>231-48-7883</b>		5. SEX <b>1</b> M <b>2</b> F		6. AGE (In yrs. last birthday) <b>95</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>4-20-95</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Baltimore County General Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Randallstown</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
10a. STATE <b>Md.</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? <b>1</b> YES <b>2</b> NO	
10e. STREET AND NUMBER <b>4100 Bedford Rd.</b>				10f. ZIP CODE <b>21207</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <b>1</b> Never Married <b>2</b> Married <b>3</b> Widowed <b>4</b> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> YES <b>2</b> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> YES <b>2</b> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Bethlehem Steel</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Steel</b>			
17. FATHER'S NAME (First, Middle, Last) <b>William Hamlett</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Nannie Barksdale</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Violet H. Willis</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4100 Bedford Rd. Balto., Md. 21207</b>			
20a. METHOD OF DISPOSITION <b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Mr. Ellis Church Cem.</b>		20c. LOCATION — City or Town, State <b>Keysville, Va.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>James A. Morton</b>				22. NAME AND ADDRESS OF FACILITY <b>James A. Morton &amp; Sons 1701 Laurens St. Balto., Md. 21217</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Aspiration Pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>b. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>c. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>d.</b>							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <b>1</b> YES <b>2</b> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1</b> YES <b>2</b> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> YES <b>2</b> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA OTHER: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify)					
27. MANNER OF DEATH <b>1</b> Natural <b>5</b> Pending Investigation <b>2</b> Accident <b>6</b> Could not be determined <b>3</b> Suicide <b>4</b> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK? <b>1</b> YES <b>2</b> NO	
		28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <b>1</b> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUMBER <b>D37944</b>		29d. DATE SIGNED (Month, Day, Year) <b>3-5-91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>5401 Old Court Road Randallstown, Maryland, 21133</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 6 1991</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 05860

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) RUTH ESTELLE HARRIS				2. DATE OF DEATH MONTH DAY YEAR March 5 1991		3. TIME OF DEATH 1029 A.M.	
4. SOCIAL SECURITY NUMBER 213-20-8103		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 65 YRS.	7. DATE OF BIRTH (Month, Day, Year) JUNE 26, 1925		8. BIRTHPLACE (State or Foreign Country) MARYLAND	
9a. FACILITY NAME (If not institution, give street and number) ST. AGNES HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		9c. COUNTY OF DEATH	
10a. STATE MARYLAND				10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION BALTIMORE	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 2661 FREDERICK AVENUE		10f. ZIP CODE 21223	
10g. CITIZEN OF WHAT COUNTRY? U.S.A.				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yea or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: WHITE		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9th GRADE College (1-4 or 5+) College (1-4 or 5+)	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER				16b. KIND OF BUSINESS/INDUSTRY		17. FATHER'S NAME (First, Middle, Last) NORMAN FREEBURGER	
18. MOTHER'S NAME (First, Middle, Maiden Surname) HARRIET SEHMAN				19a. INFORMANT'S NAME (Type/Print) ROBERT HARRIS, JR.		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 75 BAJA WAY, HALETHORPE, MD. 21227	
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) CRESTLAWN CEMETERY		20c. LOCATION — City or Town, State BALTIMORE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Raymond Patterson</i>				22. NAME AND ADDRESS OF FACILITY HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE, BALTIMORE, MD. 21229		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Right Cerebral Vascular Accident DUE TO (OR AS A CONSEQUENCE OF): b. Hypertension DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 28d. DESCRIBE HOW INJURY OCCURRED 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Abmed Husari</i>		29c. LICENSE NUMBER D37353	
29d. DATE SIGNED (Month, Day, Year) March - 5 - 1991				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Abmed Husari, MD 1/2 St Agnes Hospital 900 Caton Ave Balt. MD		31. DATE FILED (Month, Day, Year) MAR 06 1991	
32. REGISTRAR'S SIGNATURE <i>J. Harrison-Randell</i>				33. DATE OF DEATH MAR 06 1991		34. TIME OF DEATH 1029 A.M.	

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05861

1. DECEDENT'S NAME (First, Middle, Last) <b>MARIANNA KASPRZYK</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>5</b> YEAR <b>91</b>		3. TIME OF DEATH <b>9:35 AM</b>							
4. SOCIAL SECURITY NUMBER <b>219-54-3177</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) <b>94</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>12/12/1896</b>		6. BIRTHPLACE (State or Foreign Country) <b>POLAND</b>					
9a. FACILITY NAME (If not institution, give street and number) <b>FOREST HAVEN NURS. HOME</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>CATONSVILLE</b>			9c. COUNTY OF DEATH <b>BALTIMORE</b>						
10a. STATE <b>MD.</b>		10b. COUNTY <b>BALTIMORE</b>		10c. CITY, TOWN OR LOCATION <b>21229</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER <b>315 INGLETSIDE AVE.</b>				10f. ZIP CODE <b>21229</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>						
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>UNKNOWN</b> College (1-4 or 5+) <b>—</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>—</b>			16b. KIND OF BUSINESS/INDUSTRY <b>—</b>						
17. FATHER'S NAME (First, Middle, Last) <b>LADISLAW BRULINSKI</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ANGELA SUBOROWSKA</b>									
19a. INFORMANT'S NAME (Type/Print) <b>HELEN BAUMGARTNER</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21229 4704 PARTFORD AVE. CATONSVILLE, MD.</b>									
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>HOLY ROSARY CEM.</b>			20c. LOCATION — City or Town, State <b>BALTIMORE, MD.</b>								
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>—</b>				22. NAME AND ADDRESS OF FACILITY <b>EDWARD J. WEBER F.A. 401 S. CHESTER ST. BALTIMORE, MD. 21231</b>									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CEREBRAL THROMBOSIS</b> Due to (or as a consequence of): a. <b>—</b> b. <b>—</b> c. <b>—</b> d. <b>—</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>MULTI INFARCT DEMENTIA.</b> <b>ATHEROSCLEROTIC CARDIO VASCULAR DISEASE</b>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <b>—</b>		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED <b>—</b>	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <b>Tasneem Lakhan MD</b>				29c. LICENSE NUMBER <b>D28895</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/5/91</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>TASNEEM LAKHANI, 7230 PARK HEIGHTS AVE. BALTIMORE MD 21208</b>													
31. DATE FILED (Month, Day, Year) <b>MAR 06 1991</b>				32. REGISTRAR'S SIGNATURE <b>—</b>									





BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed and signed by the attending physician and completed in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05862

1. DECEDENT'S NAME (First, Middle, Last) Bertram I. KERRY				2. DATE OF DEATH MONTH 03 DAY 01 YEAR 1991				3. TIME OF DEATH 11:37 P			
4. SOCIAL SECURITY NUMBER 216 16 3387 A		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 65 YRS.		7. DATE OF BIRTH (Month, Day, Year) 6-6-1925		8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE				9c. COUNTY OF DEATH BALTIMORE CITY			
10a. STATE Maryland		10b. COUNTY Baltimore County		10c. CITY, TOWN OR LOCATION Lansdowne				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 207 - 3rd Avenue				10f. ZIP CODE 21227		10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES World War II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9th Grade		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Television Repair		16b. KIND OF BUSINESS/INDUSTRY Television Repair							
17. FATHER'S NAME (First, Middle, Last) William S. Kerry				18. MOTHER'S NAME (First, Middle, Maiden Surname) Laura I. Baker							
19a. INFORMANT'S NAME (Type/Print) Verna Kerry				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 207 - 3rd Avenue Baltimore, Maryland 21227							
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory, Inc.		20c. LOCATION — City or Town, State Baltimore, Maryland							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Jerome Znamenski				22. NAME AND ADDRESS OF FACILITY George J. Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Cardiopulmonary Arrest</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>Vertebral Basilar Insufficiency</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>Cerebral Vascular Accident</u> DUE TO (OR AS A CONSEQUENCE OF): d. Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death Immediate 1 Month LESS THAN 1 YEAR			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Hypertension</u> <u>Coronary Artery Disease</u>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER J. A. Kemp MD				29c. LICENSE NUMBER F9408		29d. DATE SIGNED (Month, Day, Year) 3/1/91					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Johns Hopkins Hospital											
31. DATE FILED (Month, Day, Year) MAR 06 1991				32. REGISTRAR'S SIGNATURE Julia Davidson-Rendell							



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05863

1. DECEDENT'S NAME (First, Middle, Last) JOSEPH G. KERNAN				2. DATE OF DEATH MONTH DAY YEAR MARCH 3, 1991		3. TIME OF DEATH 8:00 P M					
4. SOCIAL SECURITY NUMBER 215-05-6346		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (in yrs. last birthday) 74 YRS.		7. DATE OF BIRTH (Month, Day, Year) JULY 7, 1916		8. BIRTHPLACE (State or Foreign Country) MARYLAND			
9a. FACILITY NAME (If not institution, give street and number) MERIDIAN NURSING HOME				9b. CITY, TOWN OR LOCATION OF DEATH CATONSVILLE			9c. COUNTY OF DEATH BALTIMORE				
10a. STATE MARYLAND				10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 1201 WASHINGTON BOULEVARD				10f. ZIP CODE 21230		10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: WHITE				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH GRADE		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) TRUCK DRIVER		16b. KIND OF BUSINESS/INDUSTRY BALTIMORE CITY PARKS							
17. FATHER'S NAME (First, Middle, Last) JOSEPH GROVER KERNAN, SR.				18. MOTHER'S NAME (First, Middle, Maiden Surname) EDITH LONG							
19a. INFORMANT'S NAME (Type/Print) PATRICK M. PROBST				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6651 WOODBINE RD., WOODBINE, MD. 21297							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) LOUDON PARK CEMETERY		DATE 3/5		20c. LOCATION — City or Town, State BALTIMORE					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE M. Neal Colerem				22. NAME AND ADDRESS OF FACILITY HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE, BALTIMORE, MD. 21229							
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CVA Hypertensive ASCVD DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER John A. Shaw MD						29c. LICENSE NUMBER D12967		29d. DATE SIGNED (Month, Day, Year) 3/4/91			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John A. Shaw MD 5800 Edmondson Ave Bal. Md. 21228											
31. DATE FILED (Month, Day, Year) MAR 06 1991				32. REGISTRAR'S SIGNATURE John Davidson-Randall							



ITEMS:1,17,18 per FH  
G-674 4/1/91 cm

91 05864

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>PEARL L. KANAROWSKI</u>				2. DATE OF DEATH MONTH <u>3</u> DAY <u>2</u> YEAR <u>91</u>		3. TIME OF DEATH <u>8:30</u> A M						
4. SOCIAL SECURITY NUMBER <u>300 24 5595</u>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>76</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>May 10, 1914</u>		8. BIRTHPLACE (State or Foreign Country) <u>Pennsylvania</u>				
9a. FACILITY NAME (If not institution, give street and number) <u>1329 Excaliber Lane</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>Sandy Spring</u>			9c. COUNTY OF DEATH <u>Montgomery</u>					
10a. STATE <u>Maryland</u>		10b. COUNTY <u>Montgomery</u>		10c. CITY, TOWN OR LOCATION <u>Sandy Spring</u>			10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO					
10e. STREET AND NUMBER <u>1329 Excaliber Lane</u>				10f. ZIP CODE <u>20860</u>			10g. CITIZEN OF WHAT COUNTRY? <u>United States</u>					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <u>Elementary/Secondary (0-12)</u> <u>12</u>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Homemaker</u>			16b. KIND OF BUSINESS/INDUSTRY <u>Home</u>					
17. FATHER'S NAME (First, Middle, Last) <u>Alexander Lewis</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Mary Gwozdz</u> <u>MARY GWOZD</u>								
19a. INFORMANT'S NAME (Type/Print) <u>Stanley M. Kanarowski</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Same address as #10</u>								
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Calvary Cemetery</u>			20c. LOCATION — City or Town, State <u>Toledo, Ohio</u>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Donald D. Carson</u> #M00690				22. NAME AND ADDRESS OF FACILITY <u>Ives-Pearson Funeral Homes</u> <u>2847 Wilson Blvd, Arlington, VA 22201</u>								
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Neck</u> <u>Lymphosarcoma = metastatic</u> DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <u>Dysphagia 20+1</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>S/P neck resection / esophageal resection</u> DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death <u>6 mos</u> <u>4 mos</u> <u>16 yrs</u>												
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>perforated esophagus gastrostomy</u> <u>malnutrition</u>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Julia Davidson-Randall</u>						29c. LICENSE NUMBER <u>D18716</u>		29d. DATE SIGNED (Month, Day, Year) <u>3/2/91</u>				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>18111 Prince Philip Dr. Olney, MD 20832</u>												
31. DATE FILED (Month, Day, Year) <u>MAR 06 1991</u>				32. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>								

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 5 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				CERTIFICATE OF DEATH				REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last) Clara E. Koyce						2. DATE OF DEATH MONTH 3 DAY 1 YEAR 1991				3. TIME OF DEATH M					
4. SOCIAL SECURITY NUMBER 219-10-5029		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) 12-18-08		8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not institution, give street and number) 2 Sommers Court						9b. CITY, TOWN OR LOCATION OF DEATH Cockeysville				9c. COUNTY OF DEATH Baltimore					
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Cockeysville				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 2 Sommers Court				10f. ZIP CODE 21030				10g. CITIZEN OF WHAT COUNTRY? USA							
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife				16b. KIND OF BUSINESS/INDUSTRY Homemaking									
17. FATHER'S NAME (First, Middle, Last) George P. Isenrock						18. MOTHER'S NAME (First, Middle, Maiden Surname) Ella Russell									
19a. INFORMANT'S NAME (Type/Print) Mrs. Leslie R. Robinson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11310 Glen Arm Rd. Glen Arm, Md. 21057											
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Fork Methodist Church Cemetery Fork, Maryland				20c. LOCATION — City or Town, State									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE E. E. Lassahn Funeral Home				22. NAME AND ADDRESS OF FACILITY E. E. Lassahn Funeral Home 11750 Belair Rd. Kingsville, Md. 21087											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Liver Failure Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. 2° to Ca of colon with c. Diffuse Liver Metastases. d.										Approximate Interval Between Onset and Death					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)													
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED							
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)											
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER MD. PA.						29c. LICENSE NUMBER D02092		29d. DATE SIGNED (Month, Day, Year) 3/4/91							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Constantinos P. Chilimindris GBMC 6701 N. Charles St. Towson, Md. 21204 Room 4594 -(4th Floor)															
31. DATE FILED (Month, Day, Year) MAR 06 1991				32. REGISTRAR'S SIGNATURE Julia Davidson-Hendell											





91 05866

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MARY M. LOMONICO</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>4</b> YEAR <b>91</b>		3. TIME OF DEATH <b>2:01 A M</b>	
4. SOCIAL SECURITY NUMBER <b>213 12 2878 A</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>82</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>12-26-1908</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>UNION MEMORIAL HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>		9c. COUNTY OF DEATH <b>=====</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>=====</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>6101 Loch Raven Blvd. Apt. 206</b>			
10f. ZIP CODE <b>21239</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th Grade</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>		16. KIND OF BUSINESS/INDUSTRY <b>Home Maker</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Reese Haddaway</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Elizabeth Freeman</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Sylvan Gray</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1002 Primrose Road Apt 102 Annapolis, Maryland 21403</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Woodlawn Cemetery</b>		20c. LOCATION — City or Town, State <b>Baltimore, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George J. Gonce</i>				22. NAME AND ADDRESS OF FACILITY <b>George J. Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CHF</b> a. DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>AFib</b> b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>COPD</b>						Approximate Interval Between Onset and Death <b>1 week</b> <b>1 month</b>	
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29a. SIGNATURE AND TITLE OF CERTIFIER <i>James A. Coomes, M.D.</i>				29c. LICENSE NUMBER <b>D40670</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/4/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>James A. Coomes, M.D. 201 E. Univ Pkwy. Baltimore, MD. 21218</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 06 1991</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

100-100000

100-100000

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05867

1. DECEDENT'S NAME (First, Middle, Last) <b>DANIEL LEISENDRING</b>				2. DATE OF DEATH MONTH DAY YEAR <b>03 / 01 / 91</b>		3. TIME OF DEATH <b>6:40 A M</b>					
4. SOCIAL SECURITY NUMBER <b>212-14-2128</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>70</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>2/11/21</b>		8. BIRTHPLACE (State or Foreign Country) <b>Unknown</b>			
9a. FACILITY NAME (If institution, give street and number) <b>St. Agnes Hospital Baltimore</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>				9c. COUNTY OF DEATH			
10a. STATE <b>Maryland</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER <b>22 S. Athol Avenue</b>				10f. ZIP CODE <b>21229</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Unknown</b>		16b. KIND OF BUSINESS/INDUSTRY					
17. FATHER'S NAME (First, Middle, Last) <b>Unknown</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Unknown</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Shirley A. Grandison</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>22 S. Athol Ave Baltimore Md 21229</b>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Western Star</b>		20c. LOCATION — City or Town, State <b>Catonsville, Md</b>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Shirley Adams Jones</b>				22. NAME AND ADDRESS OF FACILITY <b>Marshall W Jones, Jr FA PA 4101 Edmondson Ave Baltimore Md 21229</b>							
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>D. M Diabetes mellitus</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <b>A. Ahmed M.D.</b>								29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>3/4/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>A. AHMED M.D. 300 Armorey Place Baltimore M.D. 21201</b>											
31. DATE FILED (Month, Day, Year) <b>MAR 06 1991</b>				32. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>							

1. The first part of the paper is devoted to a discussion of the

history of the problem and the various methods which have been

used to solve it. It is found that the most satisfactory

method is the one which is based on the use of the

method of the least squares. This method is the one which

is used in the present paper. It is found that the

method of the least squares is the one which is the most

satisfactory. It is found that the method of the least

squares is the one which is the most satisfactory. It is found that the

method of the least squares is the one which is the most

satisfactory. It is found that the method of the least

squares is the one which is the most satisfactory. It is found that the

91 05868

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ELLA Logan / ELLA MAE LOGAN</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>5</b> YEAR <b>91</b>		3. TIME OF DEATH <b>6 A M</b>	
4. SOCIAL SECURITY NUMBER <b>259-26-4050</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) <b>73</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>12-23-17</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Mason F Lord Chronic Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH <b>Baltimore City</b>	
10a. STATE <b>MD</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTIMORE, CITY</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>558 ROBERT STREET</b>				10f. ZIP CODE <b>21217</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>UNKNOWN</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>UNKNOWN</b>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>WILL BUTLER</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MATTIE BELLE WILLIAMS</b>			
19a. INFORMANT'S NAME (Type/Print) <b>ELIZABETH HORNE</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2403 PICKERING DR./BALTIMORE, MD. 21234</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>VOSHELL MEMORIAL PARK</b>		20c. LOCATION — City or Town, State <b>BALTIMORE, MD.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Bladine Warner</b>				22. NAME AND ADDRESS OF FACILITY <b>WM.C. MARCH F.H. 1101 E. NORTH AVE.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Sepsis</b>  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <b>Aspiration</b>  <b>Dementia</b> </div> <div style="width: 35%;"> Approximate Interval Between Onset and Death </div> </div>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CVA, Seizures, malnutrition, PVD, pancreatitis, MRSA</b>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>J. J. J. J.</b>				29c. LICENSE NUMBER <b>D 24334</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/5/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Lorrie Zelesnick 5200 Eastern Ave Balto, MD 21224</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 6 1991</b>		32. REGISTRAR'S SIGNATURE <b>J. J. J. J.</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 05869

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MARY CATHERINE MAY</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>3</b> YEAR <b>91</b>		3. TIME OF DEATH <b>0628</b> M	
4. SOCIAL SECURITY NUMBER <b>215-26-6327</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>77</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>4/28/13</b>	
8. FACILITY NAME (If not institution, give street and number) <b>Saint Agnes Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>900 CATON AVENUE, BALTIMORE, MD</b>		9c. COUNTY OF DEATH <b>Baltimore City</b>	
10a. STATE <b>MD</b>				10b. COUNTY <b>Anne Arundel</b>		10c. CITY, TOWN OR LOCATION <b>Glen Burnie</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>16 Harvard Road</b>			
10f. ZIP CODE <b>21061</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th Grade</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Administrator</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Hospital</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Benjamin Edward Witt</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Love</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Rev. R. Eugene May</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>16 Harvard Road, Glen Burnie, MD, 21061</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Crestlawn Cemetery</b>		20c. LOCATION — City or Town, State <b>Baltimore, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>George J. Gonce</b>				22. NAME AND ADDRESS OF FACILITY <b>George J. Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>MULTIPLE SYSTEM ORGAN FAILURE</b>							
DUE TO (OR AS A CONSEQUENCE OF): <b>SEPSIS</b>							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>BLADDER PERFORATION (SPONTANEOUS)</b>							
DUE TO (OR AS A CONSEQUENCE OF): <b>CHRONIC CYSTITIS</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ALZHEIMER'S DISEASE</b> <b>S/P CEREBROVASCULAR ACCIDENT</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>David M. Hayward MD</b>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>3/3/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>GERALD M HAYWARD</b>							
31. DATE FILED (Month, Day, Year) <b>3/3/91 MAR 06 1991</b>				32. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05870

1. DECEDENT'S NAME (First, Middle, Last) BRUNO G. MEDELIS				2. DATE OF DEATH MONTH DAY YEAR 03 04 91		3. TIME OF DEATH 10:20 P M							
4. SOCIAL SECURITY NUMBER 219-28-0442		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 78 YRS.		7. DATE OF BIRTH (Month, Day, Year) AUG. 21, 1912		8. BIRTHPLACE (State or Foreign Country) BALTIMORE					
9a. FACILITY NAME (If not institution, give street and number) BON SECOURS HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE			9c. COUNTY OF DEATH						
10a. STATE MARYLAND			10b. COUNTY		10c. CITY, TOWN OR LOCATION BALTIMORE			10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO					
10e. STREET AND NUMBER 1346 JAMES STREET				10f. ZIP CODE 21223		10g. CITIZEN OF WHAT COUNTRY? U.S.A.							
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 YRS		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LIBRARIAN		16b. KIND OF BUSINESS/INDUSTRY STATE OF MARYLAND									
17. FATHER'S NAME (First, Middle, Last) UNKNOWN MEDELIS				18. MOTHER'S NAME (First, Middle, Maiden Surname) UNKNOWN									
19a. INFORMANT'S NAME (Type/Print) STASE MEDELIS				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1346 JAMES STREET, BALTIMORE, MD. 21223									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) LOUDBON PARK MAUSOLEUM		20c. LOCATION — City or Town, State BALTIMORE									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Kevin P. Smith</i>				22. NAME AND ADDRESS OF FACILITY HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE, BALTIMORE, MD. 21223									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>CARDIORESPIRATORY ARREST</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>RESPIRATORY-RENAL FAILURE</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>SEPSIS</u> DUE TO (OR AS A CONSEQUENCE OF): d. <u>GANGRENE OF BOWEL</u> Approximate Interval Between Onset and Death 10' 7 DAYS 10 DAYS 2 WEEKS						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>MULTIPLE MYELOMA</u>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28t. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. J. Davidson-Randall</i> MD						29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) 3/4/91					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)													
31. DATE FILED (Month, Day, Year) MAR 06 1991				32. REGISTRAR'S SIGNATURE <i>Juha Davidson-Randall</i>									



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05871

1. DECEDENT'S NAME (First, Middle, Last) <b>ARTHUR ROBERT MELVILLE</b>				2. DATE OF DEATH MONTH <b>03</b> DAY <b>03</b> YEAR <b>91</b>		3. TIME OF DEATH <b>12:10A M</b>	
4. SOCIAL SECURITY NUMBER <b>214-18-3283</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>88</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>11-14-02</b>		8. BIRTHPLACE (State or Foreign Country) <b>ENGLAND</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>GREATER BALTIMORE MEDICAL CENTER</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>TOWSON</b>		9c. COUNTY OF DEATH <b>BALTIMORE</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>BALTIMORE</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>3010 TAYLOR AVE</b>				10f. ZIP CODE <b>21234</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>N/A</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Factory Worker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Lever Brothers</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Unknown</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Maude Unknown</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mrs. Evelyn A. Melville</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3010 Taylor Avenue Baltimore, Maryland 21234</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metro Crematory Inc.</b>		DATE		20c. LOCATION — City or Town, State <b>Baltimore, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>LASSAND FUNERAL HOME</b>				22. NAME AND ADDRESS OF FACILITY <b>7401 BELAIR RD 21232</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>INTRACRANIAL HEMORRHAGE</b>  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  Due to (or as a consequence of):  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Pneumonia</b>						Approximate Interval Between Onset and Death	
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Anthony Scarpis</b>				29c. LICENSE NUMBER <b>D37362</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/3/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>SERAFIS 6212 YORK Ad</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 06 1991</b>				32. REGISTRAR'S SIGNATURE <b>Lidia Davidson-Randall</b>			



91 05872

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Randolph L. Miller</b>		2. DATE OF DEATH MONTH <b>2</b> DAY <b>28</b> YEAR <b>91</b>		3. TIME OF DEATH <b>0500 A.M.</b>
4. SOCIAL SECURITY NUMBER <b>233-34-2913</b>	5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>76</b> YRS. IF UNDER 1 YEAR: MONTHS _____ DAYS _____ IF UNDER 24 HRS.: HOURS _____ MIN. _____	7. DATE OF BIRTH (Month, Day, Year) <b>MAR. 13, 1914</b>	
8. BIRTHPLACE (State or Foreign Country) <b>WEST VIRGINIA</b>		9. FACILITY NAME (If not institution, give street and number) <b>WASHINGTON COUNTY HOSPITAL</b>		
9a. CITY, TOWN OR LOCATION OF DEATH <b>HAGERSTOWN</b>		9b. COUNTY OF DEATH <b>WASHINGTON</b>		
10a. STATE <b>WV</b>		10b. COUNTY <b>BERKELEY</b>		10c. CITY, TOWN OR LOCATION <b>FALLING WATERS</b>
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>P. O. BOX 786</b>		
10f. ZIP CODE <b>25419</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) _____		
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>LABORER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>FAIRCHILD AIRCRAFT NATIONAL PARK SERVICE</b>		
17. FATHER'S NAME (First, Middle, Last) <b>FRAZIER MILLER</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>NORMA LANDIS</b>		
19a. INFORMANT'S NAME (Type/Print) <b>MRS. CHARLOTTIE S. MILLER</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P. O. BOX 786, FALLING WATERS, WV 25419</b>		
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) _____		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>HARMONY CEMETERY</b>		20c. LOCATION — City or Town, State <b>RFD, FALLING WATERS, WV</b>
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Charles M. Brown</b>		22. NAME AND ADDRESS OF FACILITY <b>BROWN FUNERAL HOME, 327 W. KING ST. PO BOX 821, MARTINSBURG, WV 25401</b>		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardio-pulmonary arrest</b> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>Probable Pulmonary Embolus</b> DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):				Approximate Interval Between Onset and Death <b>minutes</b> <b>2 hrs.</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Coronary artery disease</b> <b>Type II Diabetes</b>				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) _____		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Martin W. Gallagher MD</b>		29c. LICENSE NUMBER <b>D31880</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/28/91</b>
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR. MARTIN GALLAGHER, HAGERSTOWN, MD 21740</b>				
31. DATE FILED (Month, Day, Year) <b>MAR 06 1991</b>		32. REGISTRAR'S SIGNATURE <b>Julia [Signature]</b>		

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



REG. NO.

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within \_\_\_\_\_ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





91 05874

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ROBERT POWELL</b>				2. DATE OF DEATH MONTH <b>03</b> DAY <b>01</b> YEAR <b>1991</b>				3. TIME OF DEATH <b>12:38 P M</b>	
4. SOCIAL SECURITY NUMBER <b>215-30-2882</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>54</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>12-27-36</b>		8. BIRTHPLACE (State or Foreign Country) <b>N.C.</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>THE JOHNS HOPKINS HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>				9c. COUNTY OF DEATH <b>BALTIMORE CITY</b>	
10a. STATE <b>MD</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTIMORE, CITY</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1807 E. NORTH AVE.</b>				10f. ZIP CODE <b>21213</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9TH</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>CITY ROOFING CO.</b>		16b. KIND OF BUSINESS/INDUSTRY					
17. FATHER'S NAME (First, Middle, Last) <b>OWENS POWELL</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>CELESTE POWELL</b>					
19a. INFORMANT'S NAME (Type/Print) <b>ERNESTINE McDANIEL</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1807 E. NORTH AVE./BALTIMORE, MD. 21213</b>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>ARBUTUS MEMORIAL PARK</b>		DATE		20c. LOCATION — City or Town, State <b>ARBUTUS, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Bladys Waver</b>				22. NAME AND ADDRESS OF FACILITY <b>WM.C. MARCH F.H. 1101 E. NORTH AVE.</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Esophageal cancer, attempted stent placement</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Esophageal cancer</b> DUE TO (OR AS A CONSEQUENCE OF):  <b>H/o alcoholism</b> <b>H/o smoking</b>								Approximate Interval Between Onset and Death <b>3 yrs</b> <b>3 yrs</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>H/o alcoholism</b> <b>H/o smoking</b>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29b. SIGNATURE AND TITLE OF CERTIFIER <b>MD, PhD</b>	
29c. LICENSE NUMBER								29d. DATE SIGNED (Month, Day, Year) <b>3/1/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MARTIN POMPER, MD, PhD.</b> <b>600 N. WOLFE Street</b> <b>BALTIMORE, MD 21205</b>									
31. DATE FILED (Month, Day, Year) <b>MAR 6 1991</b>								32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Rodriguez</b>	

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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91 05875

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) <b>Anne Pitt</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>3</b> YEAR <b>91</b>		3. TIME OF DEATH <b>7:05A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>577 38 8749</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>79</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>May 24 1911</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Alabama</b>		9a. FACILITY NAME (If not institution, give street and number) <b>Hebrew Home of Greater Washington. Rockville</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Montgomery</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Silver Spring</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>714 Lowander Lane</b>			
10f. ZIP CODE <b>20901</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Secretary</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Private</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Isadore Rossner</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Ela Ginsburg</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Betty Siegel</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5 Locksley Ct. Silver Spring Md. 20904</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>King David Memorial Gardens Falls Church, Va.</b>		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY <b>Ives-Pearson Funeral Homes Falls Church Va. 22046</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Pleural effusions</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Congestive Heart Failure</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Metastatic Breast Cancer</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Atherosclerotic Heart Disease</b> <b>Pacemaker, Aortic Stenosis</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D35579</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/3/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Susan J. Miller, MD Hebrew Home of Gtr. Wash. 6121 Montrose Rd Rockville, MD 20852</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 06 1991</b>		32. REGISTRAR'S SIGNATURE 					

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 05876

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>SAMUEL POLLACK</b>		2. DATE OF DEATH MONTH <b>March</b> DAY <b>1</b> , YEAR <b>1991</b>		3. TIME OF DEATH <b>10:30 P. M.</b>	
4. SOCIAL SECURITY NUMBER <b>578-38-0744</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>77</b> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <b>Feb. 13, 1914</b>		8. BIRTHPLACE (State or Foreign Country) <b>New York City</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Holy Cross Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Silver Spring</b>		9c. COUNTY OF DEATH <b>Montgomery</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Silver Spring</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>827 Gregorio Drive</b>		10f. ZIP CODE <b>20901</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4 Years</b> College (1-4 or 5+) <b>4 Years</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Chemist</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Gov't Printing Office</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Meyer Pollack</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Dena Kaplan</b>			
19a. INFORMANT'S NAME (Type/Print) <b>G. Esther Pollack</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>(Same as # 10)</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>King David Memorial Garden 3/3/91 Falls Church, Va.</b>		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Donald C. Stettin</b>		22. NAME AND ADDRESS OF FACILITY <b>D.M. STEIN HEBREW MEMORIAL FUNERAL HOME, INC. 232 CARROLL STREET, N.W., WASHINGTON, D.C.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. ① Cerebral Infarction with Coma</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  <b>b. c. d.</b>  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>old hemiplegia</b>					Approximate Interval Between Onset and Death <b>8 days</b>
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Dufosse</b>		29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>3/1/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>D. K. JOSH. M.D.</b>					
31. DATE FILED (Month, Day, Year) <b>MAR 06 1991</b>		32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Rendell</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146



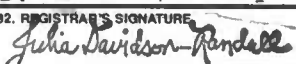
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05877

1. DECEDENT'S NAME (First, Middle, Last) <b>Josephine Pegram</b>		2. DATE OF DEATH MONTH DAY YEAR <b>February 27, 1991</b>		3. TIME OF DEATH <b>9:28 P M</b>	
4. SOCIAL SECURITY NUMBER		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>77 YRS.</b>	
7. DATE OF BIRTH (Month, Day, Year) <b>2-14-14</b>		8. BIRTHPLACE (State or Foreign Country) <b>VA</b>		9. COUNTY OF DEATH	
9a. FACILITY NAME (If not institution, give street and number) <b>Maryland General Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>		9c. COUNTY OF DEATH	
10a. STATE <b>MD</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>1800 Hollins St</b>		10f. ZIP CODE <b>21223</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>College (1-4 or 5+)</b>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Domestic</b>		16b. KIND OF BUSINESS/INDUSTRY		17. FATHER'S NAME (First, Middle, Last) <b>Oscar Lyles</b>	
18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Lessie Pryor</b>		19a. INFORMANT'S NAME (Type/Print) <b>Ilee Avery</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1838 W. Baltimore St., Balto., MD. 21223</b>	
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Western Star</b>		20c. LOCATION — City or Town, State <b>Gatonsville, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY <b>Joseph H. Brown Jr. P.A. 1913 W. Baltimore St. Balto. 21223</b>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) →  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. <u>Recent Myocardial Infarct</u> DUE TO (OR AS A CONSEQUENCE OF):  b. <u>Severe Atherosclerotic Cardiovascular Disease</u> DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d. DUE TO (OR AS A CONSEQUENCE OF):	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>1) Remote right Pulmonary Artery Thromboembolus</u>		24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Nomiclda <input type="checkbox"/> Could not be determined	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER <b>N/A</b>	
29d. DATE SIGNED (Month, Day, Year) <b>2-28-91</b>		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Daniel Sach, M.D. c/o Maryland General Hospital</b>		31. DATE FILED (Month, Day, Year) <b>MAR 06 1991</b>	
32. REGISTRAR'S SIGNATURE 					





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached to use for the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05878

1. DECEDENT'S NAME (First, Middle, Last) <b>Linda Rogers</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>3</b> YEAR <b>91</b>		3. TIME OF DEATH <b>4:00 A-M</b>				
4. SOCIAL SECURITY NUMBER <b>216-54-2369</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>42</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>04-09-48</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>		
9a. FACILITY NAME (If not institution, give street and number) <b>John Deaton Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>			9c. COUNTY OF DEATH <b>City</b>			
10a. STATE <b>MD</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTIMORE, CITY</b>			10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER <b>203 E. MT. ROYAL AVE.</b>				10f. ZIP CODE <b>21202</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>9th Grade</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>UNEMPLOYED</b>		16b. KIND OF BUSINESS/INDUSTRY						
17. FATHER'S NAME (First, Middle, Last) <b>BURGESS THORNE</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ELAINE ROBINSON</b>						
19a. INFORMANT'S NAME (Type/Print) <b>LINDA THORNE</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>203 E. MT. ROYAL AVE./BALTIMORE, MD. 21202</b>						
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>CEDAR HILL CEMETERY</b>		20c. LOCATION — City or Town, State <b>ANNE ARUNDEL CO, MD</b>						
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Bladys Wane</b>				22. NAME AND ADDRESS OF FACILITY <b>WM.C. MARCH F.H. 1101 E. NORTH AVE</b>						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Breast Cancer, metastatic</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate interval Between Onset and Death <b>3 years</b>										
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>nephrotic disease, bone metastases, liver metastases, lymphedema</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER <b>[Signature]</b>				29c. LICENSE NUMBER <b>037458</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/4/91</b>				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)										
31. DATE FILED (Month-Day, Year) <b>MAR 6 1991</b>		32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Rodale</b>								



91-698

ITEMS: 1, 4, 8, 10g, 11, 17, 18, 19a, 19b  
 per ANATOMY BOARD G-674 4/23/91 cm  
 ITEM: 24b per ME  
 G-674 4/15/91 cm

91 05879

FOR  
 STATE  
 REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) DOROTHY T. ROBERTSON				2. DATE OF DEATH MONTH DAY YEAR 2 11 91		3. TIME OF DEATH 3:55 P M	
4. SOCIAL SECURITY NUMBER 414-22-1980		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 67 YRS.		7. DATE OF BIRTH (Month, Day, Year) 8-18-1923	
8. BIRTHPLACE (State or Foreign Country) TENN		9a. FACILITY NAME (If not institution, give street and number) 1745 E. Pratt Street		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City		9c. COUNTY OF DEATH na	
10a. STATE MD		10b. COUNTY na		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1745 East Pratt Street				10f. ZIP CODE 21231		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) W.D. THOMAS				18. MOTHER'S NAME (First, Middle, Maiden Surname) SUSIE RIELLY			
19a. INFORMANT'S NAME (Type/Print) OCME ELEANOR KEMP (daughter)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 638 E FORT AVENUE BALTIMORE, MARYLAND 21230			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) in state		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		DATE		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald Wade, Dir 3/5/91				22. NAME AND ADDRESS OF FACILITY STATE ANATOMY BOARD 655 West Baltimore St, Balto, MD 21201			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic cardiovascular disease DUE TO (OR AS A CONSEQUENCE OF):  Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Ann M. Dixon, M.D.				29c. LICENSE NUMBER OCME		29d. DATE SIGNED (Month, Day, Year) 2-12-91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Ann M. Dixon, M.D. 111 Penn Street Baltimore, MD 21201							
31. DATE FILED (Month, Day, Year) MAR 6 1991		32. REGISTRAR'S SIGNATURE Julia Davidson-Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be attached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				91 05880					
CERTIFICATE OF DEATH				REG. NO.									
1. DECEDENT'S NAME (First, Middle, Last) THOMAS L ROBINSON Jr.				2. DATE OF DEATH MONTH DAY YEAR 03 01 91		3. TIME OF DEATH 2:50 P M							
4. SOCIAL SECURITY NUMBER 579-07-9363		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 80 YRS.		7. DATE OF BIRTH (Month, Day, Year) 07/07/10		8. BIRTHPLACE (State or Foreign Country) South Carolina					
9a. FACILITY NAME (If not institution, give street and number) 13008 Old Stage Coach #1212				9b. CITY, TOWN OR LOCATION OF DEATH Laurel				9c. COUNTY OF DEATH Prince George's					
10a. STATE Maryland		10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION Laurel		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER 13008 Old Stage Coach #1212				10f. ZIP CODE 20708		10g. CITIZEN OF WHAT COUNTRY? USA							
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Unknown				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Unemployed		16b. KIND OF BUSINESS/INDUSTRY N/A							
17. FATHER'S NAME (First, Middle, Last) Thomas L. Robinson, Sr				18. MOTHER'S NAME (First, Middle, Maiden Surname) Unknown									
19a. INFORMANT'S NAME (Type/Print) Oliver James				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13008 Old Stage Coach Rd/#1212/Laurel, Md 20708									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Harmony Memorial Park		20c. LOCATION — City or Town, State Landover, Md									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James G. Seal</i>				22. NAME AND ADDRESS OF FACILITY J.B. Jenkins Funeral Home 7474 Landover Rd/Landover, Md 20785									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <u>CHRONIC RESPIRATORY DYSASTH</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>Ischemic heart disease</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>AND SYMPHYLTIC AORTITIS</u> DUE TO (OR AS A CONSEQUENCE OF): d.										Approximate Interval Between Onset and Death 5 ym			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>SENILE DEMENTIA</u>										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		26. PLACE OF DEATH (Check only one) OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED					
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER <i>James G. Seal, MD - Attending</i>				29c. LICENSE NUMBER D16177				29d. DATE SIGNED (Month, Day, Year) 2-2-91					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) A.C. LORA, MD - 9326 LORAM-SOUTH RD, LORAM, MD													
31. DATE FILED (Month, Day, Year) MAR 06 1991				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randell</i>									



91 05881

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>William Lee Rippon, Jr.</b>				2. DATE OF DEATH MONTH DAY YEAR <b>February 20 1991</b>		3. TIME OF DEATH <b>0725 A M</b>	
4. SOCIAL SECURITY NUMBER <b>230-52-5015</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>78</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Apr. 3, 1912</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Virginia</b>				9a. FACILITY NAME (If not institution, give street and number) <b>PENINSULA GENERAL HOSPITAL</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>SALISBURY</b>	
9c. COUNTY OF DEATH <b>WICOMICO</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Worcester</b>	
10c. CITY, TOWN OR LOCATION <b>Berlin</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>Route 3 P.O. Box 799</b>	
10f. ZIP CODE <b>21811</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) <b>11</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Horseman &amp; Farmer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Agriculture</b>	
17. FATHER'S NAME (First, Middle, Last) <b>William Lee Rippon, Sr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Susan Hanby</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Sue Rippon Meikle</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>310 Hickory Walk Marietta, Georgia 30064</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Eastville Bapt. Cemetery</b>		20c. LOCATION — City or Town, State <b>Eastville, Va.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>James N. Fox</b>				22. NAME AND ADDRESS OF FACILITY <b>Fox Funeral Home Temperanceville, Va.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>cardio pulmonary failure</b> DUE TO (OR AS A CONSEQUENCE OF): <b>renal failure</b> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>probable cause</b> DUE TO (OR AS A CONSEQUENCE OF): <b>cellulitis of right arm</b>							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Walter Lischick MD</b>				29c. LICENSE NUMBER <b>D 31887</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/20/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Walter Lischick 560 Riverside Dr. Salisbury, Md. 21801</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 06 '91</b>				32. REGISTRAR'S SIGNATURE <b>John Davidson</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





91 05882

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Martin John Soltynski Jr.				2. DATE OF DEATH MONTH DAY YEAR 03 03 1991		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER 212 44 9785		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 45 YRS.		7. DATE OF BIRTH (Month, Day, Year) 7-16-1945	
8. BIRTHPLACE (State or Foreign Country) Maryland				9. COUNTY OF DEATH =====			
9a. FACILITY NAME (If not institution, give street and number) Francis Scott Key Medical Center				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City		9c. COUNTY OF DEATH =====	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY =====		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 4238 Frederick Avenue				10f. ZIP CODE 21229		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Viet Nam		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Carpenter		16b. KIND OF BUSINESS/INDUSTRY Building			
17. FATHER'S NAME (First, Middle, Last) Martin Soltynski Sr.				16. MOTHER'S NAME (First, Middle, Maiden Surname) Evelyn Seitz			
19a. INFORMANT'S NAME (Type/Print) Virginia Soltynski				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2511 Hammonds Ferry Road Baltimore, Maryland 21227			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Holy Cross Cemetery		20c. LOCATION — City or Town, State Baltimore, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSER <i>George J. Gonce</i>				22. NAME AND ADDRESS OF FACILITY George J. Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Intracerebral Hemorrhage</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>Coagulopathy</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>Cirrhosis</u> DUE TO (OR AS A CONSEQUENCE OF): d. <u>Alcoholism</u>  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Jeremy Walsten MD</i>				29c. LICENSE NUMBER D38849		29d. DATE SIGNED (Month, Day, Year) 3/3/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) MAR 06 1991				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 05883

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>HENRY, L., SCHAFER</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>1</b> YEAR <b>91</b>		3. TIME OF DEATH <b>6 24 AM</b>	
4. SOCIAL SECURITY NUMBER <b>213-16-5049</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>74</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>8, 9 1916</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Mercy Medical Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTO.</b>		9c. COUNTY OF DEATH <b>NA U.S.A.</b>	
10a. STATE <b>MD</b>				10b. COUNTY <b>BALTO</b>		10c. CITY, TOWN OR LOCATION <b>BALTO</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>227 S Broadway</b>			
10f. ZIP CODE <b>21231</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		15b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)			
19a. INFORMANT'S NAME (Type Print)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>in state</b>		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Ronald Wade, Dir</b> <b>3/5/91</b>		22. NAME AND ADDRESS OF FACILITY <b>STATE ANATOMY BOARD</b> <b>655 West Baltimore St, Balto, MD 21201</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Lymphoma</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death <b>3 mths</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>COPD</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>George L. ...</b>				29c. LICENSE NUMBER <b>D 20673</b>		29d. DATE SIGNED (Month, Day, Year) <b>3-1-91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>George L. ... 5810 ... Baltimore, MD 21204</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 6 1991</b>		32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be furnished to the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1/2

ITEMS:1,6,12 thru 22  
per FH G-673 3/8/91 cm

91 05884

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <b>ROBERT H STOKES, JR</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>1</b> YEAR <b>91</b>		3. TIME OF DEATH <b>10:25 AM</b>			
4. SOCIAL SECURITY NUMBER <b>217 14 0447</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>67</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>5-3-1924</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>UNION MEMORIAL HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>		9c. COUNTY OF DEATH <b>Maryland</b>			
10a. STATE <b>MD</b>		10b. COUNTY <b>na</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER <b>11 West 20th Street Apt 17J</b>				10f. ZIP CODE <b>21218</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>U.S. NAVY</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input type="checkbox"/> NO Specify: <b>NO</b>		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>12th</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Retired</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Porter</b>					
17. FATHER'S NAME (First, Middle, Last) <b>ROBERT H. STOKES, SR</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MAUDE</b>					
19a. INFORMANT'S NAME (Type/Print) <b>JANICE FOGG</b>				19b. MAILING ADDRESS (Street and Number, or Rural Route Number, City, or Town, State, Zip Code) <b>1608 NORTHBORNE ROAD BALTIMORE, MARYLAND 21239</b>					
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>in state</b>		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>GARRISON FOREST VA CEMETERY</b>		20c. LOCATION — City or Town, State <b>OWINGS MILLS, MARYLAND</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Ronald Wade, Dir</b> <i>[Signature]</i> 3/5/91				22. NAME AND ADDRESS OF FACILITY <b>MARCH FUNERAL HOME</b> <b>1101 E NORTH AVE</b> <b>655 W. Baltimore St. Balto, MD 21201</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Renal failure &amp; Respiratory failure plus metabolic</b> DUE TO (OR AS A CONSEQUENCE OF): <b>COPD</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. c. d.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Pneumonia</b> <b>CAD</b> <b>H/O ETOH abuse</b>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide 3 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>3/10/91</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MAYEZ EL H STOKES</b> <b>UMH - 201 E. ON J Pkwy</b> <b>BALTO MD 21218</b>									
31. DATE FILED (Month, Day, Year) <b>MAR 6 1991</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91-1191-510

91 05885

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) John Vincent Leonard Sciukas, Sr.				2. DATE OF DEATH MONTH DAY YEAR 3 4 1991		3. TIME OF DEATH 12:19 a.m.	
4. SOCIAL SECURITY NUMBER 216-07-3616		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 74 YRS.		7. DATE OF BIRTH (Month, Day, Year) MARCH 7, 1916	
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9a. FACILITY NAME (If not institution, give street and number) 1319 Herkimer Street		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City	
9c. COUNTY OF DEATH				10a. STATE MARYLAND		10b. COUNTY	
10c. CITY, TOWN OR LOCATION BALTIMORE				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 1319 HERKIMER STREET	
10f. ZIP CODE 21223				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10TH GRADE College (1-4 or 5+) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) TAILOR		16b. KIND OF BUSINESS/INDUSTRY T.I. SWARTZ & SONS	
17. FATHER'S NAME (First, Middle, Last) VINCENT JOHN SCIUKAS				18. MOTHER'S NAME (First, Middle, Maiden Surname) EVA KLIMAS			
19a. INFORMANT'S NAME (Type/Print) VICTORIA SMITH				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1401 FILBERT STREET, BALTIMORE, MD. 21226			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) CEDAR HILL CEMETERY 3/8		20c. LOCATION — City or Town, State BALTIMORE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE M. Heaf Colman				22. NAME AND ADDRESS OF FACILITY HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE, BALTIMORE, MD. 21229			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Atherosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic obstructive pulmonary disease							
24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER A.M. Dixon				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) 3-5-1991	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) A.M. Dixon 111 Penn Street Balto., Maryland 21201							
31. DATE FILED (Month, Day, Year) MAR 06 1991				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

91 05886

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARGARET CELESTE SCHMIDT						2. DATE OF DEATH MONTH DAY YEAR 3 - 3 - 91		3. TIME OF DEATH 9:25 PM			
4. SOCIAL SECURITY NUMBER 215-12-9777		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 69 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) NOV. 21, 1921		8. BIRTHPLACE (State or Foreign Country) MARYLAND			
9a. FACILITY NAME (If not institution, give street and number) CHARLESTOWN CARE CENTER				9b. CITY, TOWN OR LOCATION OF DEATH CATONSVILLE		9c. COUNTY OF DEATH BALTIMORE					
RESIDENCE OF DECEDENT											
10a. STATE MARYLAND		10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION BALTIMORE			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				
10e. STREET AND NUMBER 4808 WESTLAND BOULEVARD				10f. ZIP CODE 21227		10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)			15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SECRETARY			15b. KIND OF BUSINESS/INDUSTRY LOCKE INSULATOR					
17. FATHER'S NAME (First, Middle, Last) CHARLES SCHMIDT				16. MOTHER'S NAME (First, Middle, Maiden Surname) KATHERINE RYDER							
19a. INFORMANT'S NAME (Type/Print) FRED GROGG				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 N. STEPHEN PLACE, HANOVER, PA. 17331							
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) LORRAINE PARK			20c. LOCATION — City or Town, State WOODLAWN						
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Raymond P. Petersen</i>				22. NAME AND ADDRESS OF FACILITY HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE, BALTIMORE, MD. 21229							
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Possible Pulmonary Emboli DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD				29c. LICENSE NUMBER 034053		29d. DATE SIGNED (Month, Day, Year) 3/14/91					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Gary Applebaum MD 711 Madison Circle Lane 21228											
31. DATE FILED (Month, Day, Year) MAR 06 1991				32. REGISTRAR'S SIGNATURE <i>Gina Davidson-Rendell</i>							



91 05887

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Kimberly Smith</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>1</b> YEAR <b>91</b>		3. TIME OF DEATH <b>6:25 AM</b>	
4. SOCIAL SECURITY NUMBER		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>3</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>11-8-87</b>		8. BIRTHPLACE (State or Foreign Country)	
9a. FACILITY NAME (If not institution, give street and number) <b>UMMS - PICU</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE <b>MD</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1118 N Fremont Ave</b>				10f. ZIP CODE <b>21217</b>		10g. CITIZEN OF WHAT COUNTRY? <b>American US</b>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>Mark Williams</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Smith Barbara</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Barbara Smith</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1118 N Fremont Ave</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Western Star</b>		20c. LOCATION — City or Town, State <b>Catonsville, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Charlene D. Brown</b>				22. NAME AND ADDRESS OF FACILITY <b>Joseph H. Brown Jr. P.A. Balto., 21223</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>RDS -</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <div style="display: flex; align-items: center;"> <div style="font-size: 3em; margin-right: 10px;">{</div> <div> <p>a. <b>Overwhelming infection</b></p> <p>b. <b>CMV (+) - RSU (+)</b></p> <p>c. <b>HIV (+)</b></p> </div> </div>							Approximate interval between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Malnutrition - FTT</b> <b>GI Bleeding</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Gloria Heresi, MD</b>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>3/1/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Gloria Heresi, MD</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 06 1991</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 05888

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>C. RUSH STREETT, SR.</b>				2. DATE OF DEATH MONTH <b>MARCH</b> DAY <b>15</b> YEAR <b>1991</b>				3. TIME OF DEATH <b>1:30 P. M.</b>					
4. SOCIAL SECURITY NUMBER <b>212-09-7226</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>85</b> YRS.		IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS. HOURS _____ MIN. _____		7. DATE OF BIRTH (Month, Day, Year) <b>JAN 6, 1906</b>		8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>		
9a. FACILITY NAME (If not institution, give street and number) <b>LEVIN YAVI HEBREW GERIATRIC CENTER &amp; HOSPITAL</b>						9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>				9c. COUNTY OF DEATH			
RESIDENCE OF DECEDENT													
10a. STATE <b>MARYLAND</b>			10b. COUNTY <b>BALTIMORE</b>			10c. CITY, TOWN OR LOCATION <b>PERRY HALL</b>			10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
10e. STREET AND NUMBER <b>9487 SEVEN COURTS DRIVE</b>						10f. ZIP CODE <b>21236</b>			10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 YRS.</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>CARPENTER</b>				16b. KIND OF BUSINESS/INDUSTRY					
17. FATHER'S NAME (First, Middle, Last) <b>SAMUEL STREETT</b>						18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>EMMA RUTLOGE</b>							
19a. INFORMANT'S NAME (Type/Print) <b>FAMILY RECORDS</b>						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>SAME AS ABOVE</b>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>PARKWOOD CEMETERY</b>				DATE <b>3-4</b>		20c. LOCATION — City or Town, State <b>PARKVILLE MO.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>[Signature]</b>						22. NAME AND ADDRESS OF FACILITY <b>EVANS CHAPEL OF MEMORIES 8500 HARBOR ROAD - PARKVILLE</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>PNEUMONIA</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b> DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____										Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M _____		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Cecilia O. K. M.D.</b>						29c. LICENSE NUMBER <b>217037</b>			29d. DATE SIGNED (Month, Day, Year) <b>3/1/91</b>				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>ESTRELLITA O. K. M.D. - LEVIN YAVI HEBREW GERIATRIC CENTER &amp; HOSPITAL</b>													
31. DATE FILED (Month, Day, Year) <b>MAR 06 1991</b>				32. REGISTRAR'S SIGNATURE <b>[Signature]</b>									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



REG. NO.

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

**BALTIMORE, MARYLAND 21203-3146**

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

**FOR THE HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

**FOR THE FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If item 28 is marked, or item 23 shows any injury, or item 23 shows any traumatic event, the medical examiner must be notified at once.





91 05890

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <u>Elizabeth D. Velte</u> ELIZABETH D. VELTE				2. DATE OF DEATH MONTH DAY YEAR <u>03 01 91</u>		3. TIME OF DEATH <u>550P</u> M	
4. SOCIAL SECURITY NUMBER <u>213-05-4943</u>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>89</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>12/18/01</u>	
9a. FACILITY NAME (If not institution, give street and number) <u>Vindobona Nursing Home</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>Frederick</u>		9c. COUNTY OF DEATH <u>Frederick Co.</u>	
10a. STATE <u>Md.</u>				10b. COUNTY <u>Baltimore</u>		10c. CITY, TOWN OR LOCATION <u>Baltimore</u>	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER <u>619 Murdock Rd. - Baltimore, Md.</u>				10f. ZIP CODE <u>21212</u>		10g. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <u>N/A</u>		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: <u>N/A</u>		14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>N/A</u> College (1-4 or 5+) <u>N/A</u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Secretary</u>		16b. KIND OF BUSINESS/INDUSTRY <u>Insurance Company</u>			
17. FATHER'S NAME (First, Middle, Last) <u>James Macdonald</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Annie ?</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Anne F. Forder</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>513 Magnolia Ave. - Frederick, Md. 21701</u>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) _____		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Loudon Park Cemetery</u>		20c. LOCATION — City or Town, State <u>Baltimore, Md.</u>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>G. Truman Schwab</u>				22. NAME AND ADDRESS OF FACILITY <u>3512 Frederick Avenue Baltimore, Md. 21229</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Pneumonia</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>Congestive Heart Failure</u> DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST						Approximate interval between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) _____					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <u>[Signature] MD</u>		29c. LICENSE NUMBER <u>D35553</u>		29d. DATE SIGNED (Month, Day, Year) <u>3/1/91</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>609th Ave Brunswick MD 21716</u>							
31. DATE FILED (Month, Day, Year) <u>MAR 6 1991</u>		32. REGISTRAR'S SIGNATURE <u>[Signature]</u>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



ITEMS:6,7 per INFORMANT  
G-674 4/23/91 cm

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05891

1. DECEDENT'S NAME (First, Middle, Last) <b>CALVIN H. WEE MS</b>		2. DATE OF DEATH MONTH <b>03</b> DAY <b>02</b> YEAR <b>91</b>		3. TIME OF DEATH <b>3:25 A M</b>	
4. SOCIAL SECURITY NUMBER <b>219-20-5947</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>63</b> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <b>7/2/27</b>		8. BIRTHPLACE (State or Foreign Country) <b>md</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Bon Secours Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE MD</b>		9c. COUNTY OF DEATH	
10a. STATE <b>MD</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTIMORE CITY</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>823 N. BENTLEY ST.</b>		10f. ZIP CODE <b>21217</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>ARMY</b>	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8th</b> College (1-4 or 5+) <b></b>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY <b>Calvert Distillery</b>		17. FATHER'S NAME (First, Middle, Last) <b>Robert Weems SR.</b>	
18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Beatrice Lee</b>		19a. INFORMANT'S NAME (Type/Print) <b>FRANCES Weems</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1828 Mosher St / Baltimore, MD 21217</b>	
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>GARRISON Forest Vet. Cem</b>		20c. LOCATION — City or Town, State <b>Gwynns Mills, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Blondie W...</b>		22. NAME AND ADDRESS OF FACILITY <b>Wm. C. March F/H 1101 E. North Ave</b>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Carcinoma Liver</b>  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  <b>No Carcinoma head &amp; pancreas</b>  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Auto hemo. septicemia</b> <b>Auto respiratory failure; chronic alcoholism</b>	
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)	
28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. SIGNATURE AND TITLE OF CERTIFIER <b>D. Salvo</b>		29c. LICENSE NUMBER <b>D17537</b>		29d. DATE SIGNED (Month, Day, Year) <b>3.2.91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DARSHAN S. SALUJA 1600 MT Royal Ave, Balto 21217</b>		31. DATE FILED (Month, Day, Year) <b>MAR 6 1991</b>		32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>	

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05892

1. DECEDENT'S NAME (First, Middle, Last) GRAHAM E. WELCH, SR.				2. DATE OF DEATH MONTH DAY YEAR MARCH 5 1991		3. TIME OF DEATH 04:30 A <sup>M</sup>	
4. SOCIAL SECURITY NUMBER 218-09-5857		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 79 YRS.		7. DATE OF BIRTH (Month, Day, Year) APRIL 29, 1911	
9a. FACILITY NAME (If not institution, give street and number) ST. AGNES HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 5905 ST. MARYS STREET				10f. ZIP CODE 21207		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES W.W.II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4TH GRADE		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CAB DRIVER		16b. KIND OF BUSINESS/INDUSTRY CAB CO.			
17. FATHER'S NAME (First, Middle, Last) HUBERT WELCH				18. MOTHER'S NAME (First, Middle, Maiden Surname) CATHERINE HEFNER			
19a. INFORMANT'S NAME (Type/Print) EDWARD G. WELCH, SR.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 31 BESAN COURT, BALTIMORE, MD. 21207			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) WOODLAWN CEMETERY		DATE 3/7		20c. LOCATION — City or Town, State BALTIMORE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE, BALTIMORE, MD. 21229			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Cardiopulmonary arrest</u> DUE TO (OR AS A CONSEQUENCE OF):  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <u>Atherosclerotic cardiovascular disease</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>Chronic Obstructive Pulmonary disease</u> DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D17537		29d. DATE SIGNED (Month, Day, Year) 3-5-91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BARSHAN, S. SALUJA 1600 MT Royal Ave, Baltimore MD 21217							
31. DATE FILED (Month, Day, Year) MAR 06 1991		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



91 05893

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MARY LOU WALKER</b>				2. DATE OF DEATH MONTH <b>MAR</b> DAY <b>1</b> YEAR <b>1991</b>		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>74</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) <b>11-09-16</b>	
8. BIRTHPLACE (State or Foreign Country)				9a. FACILITY NAME (If not institution, give street and number) <b>2036 Ruxton Ave</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTO, Md.</b>	
9c. COUNTY OF DEATH <b>BALTO</b>				10a. STATE <b>MD</b>		10b. COUNTY <b>BALTO</b>	
10c. CITY, TOWN OR LOCATION <b>BALTO, City</b>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>2036 Ruxton Ave</b>	
10f. ZIP CODE <b>21216</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Cook</b>		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <b>Benny James</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Jeanie Mac</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Louella Fonce</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>25 S. Abington Ave., Balto., MD. 21229</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Spring Hill</b>		20c. LOCATION — City or Town, State <b>Manning, S.C.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Charlene D. Bue</b>				22. NAME AND ADDRESS OF FACILITY <b>Joseph H. Brown Jr. P.A. 1913 W. Baltimore St. Balto., MD 21223</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>METASTATIC LUNG CANCER</b> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Richard A. Siskin (Attending)</b>				29c. LICENSE NUMBER <b>D29071</b>		29d. DATE SIGNED (Month, Day, Year) <b>3.3.91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>R. KRISHNAN MD 821 N. FULTON ST #308 BALTIMORE MD 21201</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 06 1991</b>				32. REGISTRAR'S SIGNATURE <b>Jane Davidson-Randell</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

FOR STATE REGISTRAR FRANK YOUNG  
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH  
REG. NO.

91 05894

1. DECEDENT'S NAME (First, Middle, Last) <b>FRANK YOUNG</b>		2. DATE OF DEATH 3/2/91 MONTH DAY YEAR <b>03 02 91</b>		3. TIME OF DEATH <b>0911 A M</b>	
4. SOCIAL SECURITY NUMBER <b>1166-05-6446</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>81 YRS.</b>	
7. DATE OF BIRTH 1/17/10 (Month, Day, Year) <b>01-17-10</b>		8. BIRTHPLACE (State or Foreign Country) <b>NEW JERSEY</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>HOWARD COUNTY General Hosp</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Columbia</b>		9c. COUNTY OF DEATH <b>Howard</b>	
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>HOWARD</b>		10c. CITY, TOWN OR LOCATION <b>ELLCOTT CITY</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>8385 F MONTGOMERY RUN ROAD</b>		10f. ZIP CODE <b>21043</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>SALES</b>		16b. KIND OF BUSINESS/INDUSTRY <b>STATIONERY</b>		17. FATHER'S NAME (First, Middle, Last) <b>ANDREW YOUNG</b>	
18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ANNA STEINER</b>		19a. INFORMANT'S NAME (Type/Print) <b>GLORIA YOUNG (WIFE)</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8385 F MONTGOMERY RUN RD. ELLCOTT CITY MD 21043</b>	
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>WOODLAWN CEMETERY</b>		20c. LOCATION — City or Town, State <b>WOODLAWN, MARYLAND</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>		22. NAME AND ADDRESS OF FACILITY <b>LEROY &amp; RUSSELL WITZKE FUNERAL HOME 1630 EDMONDSON AVE. CATONSVILLE MARYLAND 21228</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>Acute Myocardial Infarction</b> <b>Due to (or as a consequence of):</b> <b>Atherosclerotic Heart Disease</b> <b>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> <b>5 yrs.</b>		Approximate Interval Between Onset and Death <b>~30min</b>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>Terri Gershon MD</b>		29c. LICENSE NUMBER <b>D26669</b>	
29d. DATE SIGNED (Month, Day, Year) <b>3-2-91</b>		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Howard County Genl Hosp ER - Terri Gershon MD</b>			
31. DATE FILED (Month, Day, Year) <b>MAR 6 1991</b>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			



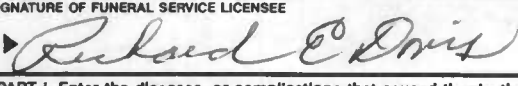
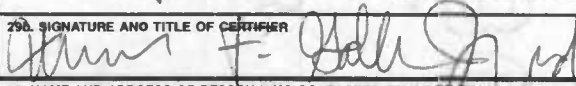
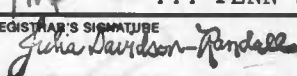
ITEMS:23,27 per ME  
G-673 3/22/91 cm

91 05895

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <b>JOHN PAUL ZAUCHA</b>		2. DATE OF DEATH MONTH <b>03</b> DAY <b>03</b> YEAR <b>91</b>		3. TIME OF DEATH <b>3:30 P M</b>
4. SOCIAL SECURITY NUMBER <b>212 48 0307</b>	5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>46</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>8-1-1945</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>		9. COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY</b>		
9a. FACILITY NAME (If not institution, give street and number) <b>307 MOUNTAIN RIDGE COURT, APARTMENT E</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>GLEN BURNIE</b>		9c. COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY</b>
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Anne arundel</b>		10c. CITY, TOWN OR LOCATION <b>Glen Burnie</b>
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>307 Mt. Ridge Court Apt. E</b>		
10f. ZIP CODE <b>21061</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8 years</b> College (1-4 or 5+) <b>Attorney</b>		
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Law</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Law</b>		
17. FATHER'S NAME (First, Middle, Last) <b>John A. Zaucha</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Sophia V. Duran</b>		
19a. INFORMANT'S NAME (Type/Print) <b>Eleanor D. Bentz</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12902 Kendale Lane Bowie, Maryland 20715</b>		
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metro Crematory, Inc. 3-6 Baltimore, Maryland</b>		20c. LOCATION — City or Town, State <b>Baltimore, Maryland</b>
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY <b>George J. Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225</b>		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>e. HYPERTENSIVE CARDIOVASCULAR DISEASE</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.				Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO				
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>M</b>		28b. TIME OF INJURY <b>1</b> YES <input type="checkbox"/> NO
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>03/04/91</b>
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MARIO F. GOLIE, JR., MD 111 PENN STREET, BALTIMORE, MARYLAND 21201</b>				
31. DATE FILED (Month, Day, Year) <b>MAR 06 1991</b>		32. REGISTRAR'S SIGNATURE 		

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

IN THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05896

1. DECEDENT'S NAME (First, Middle, Last) <b>C. Eliza Zimmerman</b>				2. DATE OF DEATH MONTH DAY YEAR <b>March 5, 1991</b>		3. TIME OF DEATH HOURS MIN. A. M. <b>5:00 A.</b>	
4. SOCIAL SECURITY NUMBER <b>203-07-0404</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>74</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>9-27-1916</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>3227 Glendale Avenue</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH <b>Pa.</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>3227 Glendale Ave.</b>				10f. ZIP CODE <b>21234</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2 Yrs.</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Medical Technician</b>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>Charles Beck</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Eliza Hess</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Judith Aguirre</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9364 Beowulf Cir., Balto., Md. 21237</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Moreland Cemetery 3-6-91</b>		20c. LOCATION — City or Town, State <b>Balto., Md.</b>		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Roy H. Cather</b> <i>Roy H. Cather</i>				22. NAME AND ADDRESS OF FACILITY <b>Leonard J. Ruck, Inc., 5305 Harford Rd., Balto., Md. 21214</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Medullary Basal Ca</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Homicide			
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>MD.</i>				29c. LICENSE NUMBER <b>D18487</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/5/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Myo Thant MD 9101 Franklin Square Drive Rossville, Md.</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 06 1991</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson</i>			



91-1155-510

91 05897

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Ruth A. Alvey</b>				2. DATE OF DEATH MONTH DAY YEAR <b>03 01 1991</b>		3. TIME OF DEATH <b>7:19 P M</b>	
4. SOCIAL SECURITY NUMBER <b>213-01-1736</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>97</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>8 8 1893</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>5622 Woodmont Ave Apt D.</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>	
9c. COUNTY OF DEATH <b>Baltimore</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Balto. City</b>	
10c. CITY, TOWN OR LOCATION <b>Balto. City</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>5622 Woodmont Ave.</b>	
10f. ZIP CODE <b>21239</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Charles C. Hook</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary C. Neenan</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mary Louise Gettier</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Baton Rouge, La.</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of Cemetery, crematory or other place) <b>Balto. National Cemetery 3/5/91</b>		20c. LOCATION — City or Town, State <b>Balto. Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>1050 York Rd. 21204 Ruck Towson Funeral Home, Inc.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Arteriosclerotic cardiovascular disease</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>03 02 1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>A. M. DIXON 111 Penn Street Baltimore Maryland 21201</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 06 1991</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05898

1. DECEDENT'S NAME (First, Middle, Last) <i>Sarah J. Bundy</i>				2. DATE OF DEATH MONTH DAY YEAR <i>03 01 91</i>		3. TIME OF DEATH <i>1910 M</i>				
4. SOCIAL SECURITY NUMBER <i>219-20-7835</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) <i>71</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>6-1-19</i>		6. BIRTHPLACE (State or Foreign Country) <i>S.C.</i>		
9a. FACILITY NAME (If not institution, give street and number) <i>Harbor View Hosp</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Balto</i>			9c. COUNTY OF DEATH			
10a. STATE <i>md</i>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <i>Balto</i>			10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER <i>6001 Cheraton Rd</i>				10f. ZIP CODE <i>21225</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>				
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (14 or 5+) <input type="checkbox"/>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Teacher</i>			16b. KIND OF BUSINESS/INDUSTRY					
17. FATHER'S NAME (First, Middle, Last) <i>Powell Cannon</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Synie Suber</i>						
19a. INFORMANT'S NAME (Type/Print) <i>James L. Bundy</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>6001 Cheraton rd Balto, md 21225</i>						
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Arbutus Mem Park</i>		20c. LOCATION — City or Town, State <i>Arbutus, md</i>						
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Portia Elron</i>				22. NAME AND ADDRESS OF FACILITY <i>Harbor View Hosp 4300 Wabash Ave</i>						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Sepsis -</i>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>Cardiorespiratory failure</i>  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Carcinoma of the bladder</i> <i>Renal failure</i>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER <i>house staff</i>						29c. LICENSE NUMBER <i>Harbor Hospital</i>		29d. DATE SIGNED (Month, Day, Year) <i>3/1/91</i>		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Rossell MD 3000 J. Hanover St. Baltimore MD</i>										
31. DATE FILED (Month, Day, Year) <i>MAR 07 1991</i>										



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05899

1. DECEDENT'S NAME (First, Middle, Last) <b>James A. Bailey, SR</b>				2. DATE OF DEATH MONTH DAY YEAR <b>03-04-91</b>		3. TIME OF DEATH <b>10:55 A.M.</b>					
4. SOCIAL SECURITY NUMBER <b>227-20-4076</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>64</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>10-10-26</b>		8. BIRTHPLACE (State or Foreign Country) <b>Va</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>LRVAMC</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>			9c. COUNTY OF DEATH <b>Baltimore</b>				
10a. STATE <b>MD</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Balto</b>			10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				
10e. STREET AND NUMBER <b>3469 Flannery Lane</b>				10f. ZIP CODE <b>21215</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)			16b. KIND OF BUSINESS/INDUSTRY <b>40 West Volkswagen</b>						
17. FATHER'S NAME (First, Middle, Last) <b>George E. Bailey</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Zemoria Savage</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Glendora Bailey</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3469 Flannery Lane Balto, Md 21215</b>							
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Garrison Forest Vet</b>		20c. LOCATION — City or Town, State <b>Quings Mills Md</b>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Portia Ebron</b>				22. NAME AND ADDRESS OF FACILITY <b>March 4380 West Wash Ave</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Hypoxia</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Adult Respiratory Distress Syndrome</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Pulmonary embolism</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate interval between Onset and Death <b>1 week</b> <b>1 week</b> <b>1 week</b>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Coronary Artery Disease</b>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input checked="" type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Joan Go MD</b>						29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>3-4-91</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Joan Go Lock Haven VA Medical Center, Baltimore MD</b>											
31. DATE FILED (Month, Day, Year) <b>MAR 07 1991</b>				32. REGISTRAR'S SIGNATURE <b>John Davidson-Hendell</b>							



1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 91 05900

1. DECEDENT'S NAME (First, Middle, Last) Cameron W. Booze				2. DATE OF DEATH MONTH 3 DAY 5 YEAR 91		3. TIME OF DEATH 11:30 a m	
4. SOCIAL SECURITY NUMBER 215-18-0721		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 69 YRS.		7. DATE OF BIRTH (Month, Day, Year) 7-26-21	
9a. FACILITY NAME (If not institution, give street and number) Franklin Square Hosp.				9b. CITY, TOWN OR LOCATION OF DEATH Balto.		9c. COUNTY OF DEATH Md.	
10a. STATE Md.		10b. COUNTY Balto.		10c. CITY, TOWN OR LOCATION		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 4417 Fieldgreen Rd.				10f. ZIP CODE 21236		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES W.W. II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Salesman		16b. KIND OF BUSINESS/INDUSTRY Nusinov Jewelry			
17. FATHER'S NAME (First, Middle, Last) William C. Booze				18. MOTHER'S NAME (First, Middle, Maiden Surname) Unknown			
19a. INFORMANT'S NAME (Type/Print) Dorothy L. Booze				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4417 Fieldgreen Rd. Balto., Md. 21236			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parkwood Cem. 3-8-91		20c. LOCATION — City or Town, State Balto., Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY John C. Miller Inc. 6415 Belair Rd. Balto., Md. 21206			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiac Arrhythmia DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Arteriosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF): c. Hypertension DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death 10 yrs 10 yrs	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Type II Diabetes						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide 4 <input type="checkbox"/>		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D01340		29d. DATE SIGNED (Month, Day, Year) 3-6-91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Theodore E. Evans M.D. 9660 Belair Road Baltimore, MD 21236							
31. DATE FILED (Month, Day, Year) MAR 7 1991				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91-442

91 05901

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>HELEN K. CORNWELL</b>				2. DATE OF DEATH MONTH DAY YEAR <b>2/28/91</b>		3. TIME OF DEATH <b>2:20 P M</b>	
4. SOCIAL SECURITY NUMBER <b>212 03 8179</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>74</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>11-13-16</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>2116 Lake Drive</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Pasadena</b>	
9c. COUNTY OF DEATH <b>Anne Arundel Co</b>				10a. STATE <b>MD</b>		10b. COUNTY <b>Anne Arundel</b>	
10c. CITY, TOWN OR LOCATION <b>Pasadena</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>2116 Lake Drive</b>	
10f. ZIP CODE <b>21122</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>NO</b>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO <b>NO</b>			
14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Retired</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Secretary/Homemaker</b>			
17. FATHER'S NAME (First, Middle, Last) <b>BOLSLAW KOLODZIEJSKI</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>FRANCES KLICZCZEWSKA</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mrs Schmidt Sister</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2116 Lake Drive, Pasadena, MD 21122</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)			
20c. LOCATION — City or Town, State				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Ronald Wade, Dir</b> <b>3/5/91</b>			
22. NAME AND ADDRESS OF FACILITY <b>STATE ANATOMY BOARD</b> <b>655 West Baltimore St, Balto, MD 21201</b>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>RESPIRATORY FAILURE</b> DUE TO (OR AS A CONSEQUENCE OF): <b>SQUAMOUS CELL CARCINOMA OF PALATE</b> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF):			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY <b>M</b>			
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <b>Serena R. Nolan MD</b>			
29c. LICENSE NUMBER <b>025010</b>				29d. DATE SIGNED (Month, Day, Year) <b>3/1/91</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Serena R. Nolan 8035 A. Harford Road, Baltimore, MD 21234</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 7 1991</b>				32. REGISTRAR'S SIGNATURE <b>John Davidson</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05902

1. DECEDENT'S NAME (First, Middle, Last) <i>Harrison H. Chambers</i>				2. DATE OF DEATH MONTH DAY YEAR <i>3-5-91</i>		3. TIME OF DEATH H M <i>9-30 A</i>				
4. SOCIAL SECURITY NUMBER <i>218-22-3868-A</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>96</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>2/26/1895</i>		8. BIRTHPLACE (State or Foreign Country) <i>Wilkesbarre, Pa.</i>		
9a. FACILITY NAME (If not institution, give street and number) <i>LIBERTY MEDICAL CENTER</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>BALTIMORE</i>				9c. COUNTY OF DEATH		
10a. STATE <i>Md.</i>			10b. COUNTY		10c. CITY, TOWN OR LOCATION <i>Balto. City</i>			10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
10e. STREET AND NUMBER <i>3330 Wilkins Ave.</i>				10f. ZIP CODE <i>21229</i>		10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>				
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify:				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>VAlet</i>		16b. KIND OF BUSINESS/INDUSTRY				
17. FATHER'S NAME (First, Middle, Last) <i>Thomas Chambers</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Carrie Chambers</i>						
19a. INFORMANT'S NAME (Type/Print) <i>Alfred H. Pickett</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>531 Main St. Roosevelt Island N.Y. 10044</i>						
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Metro Crematory</i>		DATE <i>3/7</i>		20c. LOCATION — City or Town, State <i>BALTO., Md.</i>				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Wm. Brown</i>				22. NAME AND ADDRESS OF FACILITY <i>William C. Brown Community F.H. 1206 W. North Ave.</i>						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. Aspiration pneumonia</i> DUE TO (OR AS A CONSEQUENCE OF): <i>b. Hypertensive Arteriosclerotic Cardio-vascular Diseases</i> DUE TO (OR AS A CONSEQUENCE OF): <i>c. Chronic Obstructive lung diseases</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Hypertension.</i>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER <i>R.M. Shah M.D. Medical House Physician</i>				29c. LICENSE NUMBER <i>Diagcs</i>		29d. DATE SIGNED (Month, Day, Year) <i>3/5/91</i>				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>R.M. SHAH M.D. LIBERTY Medical Center, Baltimore, Md.</i>										
31. DATE FILED (Month, Day, Year) <i>MAR 07 1991</i>				32. REGISTRAR'S SIGNATURE <i>John [Signature]</i>						



REG. NO.

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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DHMH-18 Rev 1/89



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05904

1. DECEDENT'S NAME (First, Middle, Last) WILLIAM THOMAS CRAIG				2. DATE OF DEATH MONTH DAY YEAR MARCH 4, 1991		3. TIME OF DEATH 8:00 p.m.				
4. SOCIAL SECURITY NUMBER 216-12-5325		6. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		8. AGE (In yrs. last birthday) 67 YRS.		7. DATE OF BIRTH (Month, Day, Year) 10 15 1923		8. BIRTHPLACE (State or Foreign Country) MARYLAND		
9a. FACILITY NAME (If not institution, give street and number) 1619 FURNACE DRIVE				9b. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE			9c. COUNTY OF DEATH ANNE ARUNDEL			
10a. STATE MD		10b. COUNTY ANNE ARUNDEL		10c. CITY, TOWN OR LOCATION GLEN BURNIE			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 1619 FURNACE DRIVE				10f. ZIP CODE 21061		10g. CITIZEN OF WHAT COUNTRY? U.S.A.				
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (14 or 5+) 0		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) DISPATCHER		16b. KIND OF BUSINESS/INDUSTRY TRUCKING FIRM						
17. FATHER'S NAME (First, Middle, Last) JAMES J. CRAIG, SR.				18. MOTHER'S NAME (First, Middle, Maiden Surname) MARY F. FINN						
19a. INFORMANT'S NAME (Type/Print) JAMES J. CRAIG, JR.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAME AS 10						
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) NEW CATHEDRAL CEMETERY		DATE 3/8		20c. LOCATION — City or Town, State BALTIMORE, MD				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY SINGLETON FUNERAL HOME 1 SECOND AVE. S.W. GLEN BURNIE, MD 21061						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Colon Cancer metastatic DUE TO (OR AS A CONSEQUENCE OF): b. To Liver and Peritoneum DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER 027838		29d. DATE SIGNED (Month, Day, Year) 3/5/91				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Mayer Gorbatsky 85 Aquahart Rd. Glen Burnie MD 21061										
31. DATE FILED (Month, Day, Year) MAR 7 1991				32. REGISTRAR'S SIGNATURE 						


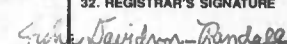


**STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH** REG. NO.

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

1. DECEDENT'S NAME (First, Middle, Last) <b>EUGENE J. DIGGS</b>				2. DATE OF DEATH MONTH <b>02</b> DAY <b>27</b> YEAR <b>1991</b>				3. TIME OF DEATH <b>5:25 P<sup>M</sup></b>	
4. SOCIAL SECURITY NUMBER <b>220-64-7998</b>		5. SEX <b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>34</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>11-23-1956</b>		8. BIRTHPLACE (State or Foreign Country) <b>Md</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>SINAI HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>				9c. COUNTY OF DEATH <b>BALTIMORE</b>	
10a. STATE <b>Md</b>				10b. COUNTY <b>Baltimore</b>				10c. CITY, TOWN OR LOCATION <b>Baltimore</b>	
10d. INSIDE CITY LIMITS? <b>1</b> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>2609 Park Heights</b>				10f. ZIP CODE <b>21215</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>U S A</b>				11. MARITAL STATUS <b>1</b> <input type="checkbox"/> Never Married <b>2</b> <input type="checkbox"/> Married <b>3</b> <input type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Cook</b>				16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <b>William T. Diggs</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Elaine Jackson</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Elaine Simmons</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5023 Pimlico Road Baltimore, Md 21215</b>					
20a. METHOD OF DISPOSITION <b>1</b> <input type="checkbox"/> Burial <b>2</b> <input checked="" type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State <b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metro Crematory</b>				20c. LOCATION — City or Town, State <b>3691 Catonsville, Md</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>March F/H West</b> <b>4300 Wabash Avenue</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>NARCOTIC INTOXICATION</b> <b>Sequently liat conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST</b> a. <b>_____</b> b. <b>_____</b> c. <b>_____</b> d. <b>_____</b>								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>_____</b> <b>_____</b>								24a. WAS AN AUTOPSY PERFORMED? <b>1</b> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1</b> <input type="checkbox"/> YES <input type="checkbox"/> NO									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input checked="" type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA OTHER: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <b>1</b> <input type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending investigation <b>2</b> <input type="checkbox"/> Accident <b>6</b> <input checked="" type="checkbox"/> Could not be determined <b>3</b> <input type="checkbox"/> Suicide <b>7</b> <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) <b>FOUND: 2/27/91</b>				28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <b>1</b> <input type="checkbox"/> YES <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED <b>SUBJECT INGESTED DRUGS</b>				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>2609 PARK HEIGHTS TIR. BALTIMORE, MARYLAND</b>	
29a. CERTIFIER (Check only one) <b>1</b> <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <b>Donald G. Wright M.D.</b>				29c. LICENSE NUMBER <b>OCME</b>	
29d. DATE SIGNED (Month, Day, Year) <b>02/28/1991</b>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DONALD G. WRIGHT, M.D.</b> <b>111 PENN STREET BALTIMORE, MARYLAND 21201</b>					
31. DATE FILED (Month, Day, Year) <b>MAR 07 1991</b>				32. REGISTRAR'S SIGNATURE 					

CIP





TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
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TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				91 05906					
CERTIFICATE OF DEATH				REG. NO.									
1. DECEDENT'S NAME (First, Middle, Last) William Henry Davis JR.				2. DATE OF DEATH MONTH DAY YEAR 3 / 5 / 91		3. TIME OF DEATH 240 P.M.							
4. SOCIAL SECURITY NUMBER 212-82-4134		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		8. AGE (In yrs., last birthday) 24 YRS.		7. DATE OF BIRTH (Month, Day, Year) 3-5-67		8. BIRTHPLACE (State or Foreign Country) MD.					
9a. FACILITY NAME (If not institution, give street and number) University Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH Baltimore							
10a. STATE MD.		10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore City		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER 3005 The Alameda				10f. ZIP CODE 21218		10g. CITIZEN OF WHAT COUNTRY? USA							
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: B							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Colleges (14 or 5+)		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Painter / Body Fender		15b. KIND OF BUSINESS/INDUSTRY									
17. FATHER'S NAME (First, Middle, Last) William H Davis SR.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Verna E. Cole									
19a. INFORMANT'S NAME (Type/Print) Wanda M. Davis				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3005 The Alameda Balto., MD. 21218									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Cedar Hill Cemetery		20c. LOCATION — City or Town, State Balto., MD.									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Wm C. Brown				22. NAME AND ADDRESS OF FACILITY Wm. C. Brown Community F.H. 1206 W. North Ave									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. SEPSIS c. Acute Myelogenous Leukemia refractory. d. DUE TO (OR AS A CONSEQUENCE OF):								Approximate Interval Between Onset and Death 3/5-3/9/91					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Harmed R. Razaadeti M.D.		29c. LICENSE NUMBER MD 37249		29d. DATE SIGNED (Month, Day, Year) 3/5/91							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Harmed R. Razaadeti M.D.													
31. DATE OF DEATH 3/5/1991													
32. REGISTRAR'S SIGNATURE Julia D. Brown													



91 05907

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ETHEL M. DAVISON (ETHEL M. DAVISON)</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>5</b> YEAR <b>91</b>		3. TIME OF DEATH <b>10:57 A</b>	
4. SOCIAL SECURITY NUMBER <b>218-32-3889</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>90</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>OCT. 19, 1900</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>BALTIMORE COUNTY GENERAL HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>RANDALLSTOWN</b>		9c. COUNTY OF DEATH <b>BALTIMORE</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>BALTIMORE</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>7920 SCOTTS LEVEL RD.</b>				10f. ZIP CODE <b>21208</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOUSEWIFE</b>		15b. KIND OF BUSINESS/INDUSTRY <b>AT HOME</b>			
17. FATHER'S NAME (First, Middle, Last) <b>ABRAHAM ROTH</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MARY (UNKNOWN)</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MRS. JUNE SACKS</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2319 SUGARCONE RD. BALTIMORE, MD 21209</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>AGUDAS ACHM ANSHE SFARD</b>		20c. LOCATION — City or Town, State <b>ROSEDALE, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Ellenore Levinson</b>		22. NAME AND ADDRESS OF FACILITY <b>SOL LEVINSON &amp; BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CHF, PULM. EDEMA</b>							
a. DUE TO (OR AS A CONSEQUENCE OF):							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CAD</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>C. Ravi MD</b>				29c. LICENSE NUMBER <b>D37333</b>		29d. DATE SIGNED (Month, Day, Year) <b>3.5.91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>C. RAVI MD, BCGH, RANDALLSTOWN, MD 21133</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 7 1991</b>		32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3145

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial record permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



ITEM:28b per ME  
G-674 4/15/91 cm

91-1184-510

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

91 05908

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Brandon A. Fenwick				2. DATE OF DEATH MONTH 3 DAY 4 YEAR 1991		3. TIME OF DEATH 7:31 a M					
4. SOCIAL SECURITY NUMBER 216-80-7419		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 27 YRS.		7. DATE OF BIRTH (Month, Day, Year) 9-20-1963		8. BIRTHPLACE (State or Foreign Country) MD			
9a. FACILITY NAME (If not institution, give street and number) UNIVERSITY HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City				9c. COUNTY OF DEATH			
10a. STATE MD		10b. COUNTY		10c. CITY, TOWN OR LOCATION BALTIMORE, CITY				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER 2302 ROUND ROAD APT-A1				10f. ZIP CODE 21225		10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) College (1-4 or 5+)		18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) FRANCIS SCOTT KEY MEDICAL CENTER				16b. KIND OF BUSINESS/INDUSTRY					
17. FATHER'S NAME (First, Middle, Last) RAYMOND FENWICK				16. MOTHER'S NAME (First, Middle, Maiden Surname) NATALIE MCGUIRE							
19a. INFORMANT'S NAME (Type/Print) NATALIE BUTLER				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2008 PRESSTMAN ST./ BALTIMORE, MD. 21217							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) LOUDEM PARK CEMETERY		DATE		20c. LOCATION — City or Town, State BALTIMORE CO., MD.					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Blades Wanner				22. NAME AND ADDRESS OF FACILITY WM.C. MARCH F.H. 1101 E. NORTH AVE							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Veek injury</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. c. d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 3-4-1991		28b. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28c. DESCRIBE HOW INJURY OCCURRED Driver IN Auto / Auto Impact	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) Street b		28b. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3100 Waterview Avenue		29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER [Signature]		29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) 3-4-1991	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print) MARIO F. COLLE JR. MD 111 Penn St. Balto.Maryland 21201				31. DATE FILED (Month, Day, Year) MAR 07 1991				32. REGISTRAR'S SIGNATURE [Signature]			

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEDENT'S NAME (First, Middle, Last) <b>BENJAMIN GUEST, BENJAMIN</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>2</b> YEAR <b>91</b>		3. TIME OF DEATH <b>8:50 P M</b>					
4. SOCIAL SECURITY NUMBER <b>215-01-9501</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>73</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>11-27-17</b>		8. BIRTHPLACE (State or Foreign Country) <b>MD</b>					
9a. FACILITY NAME (If not institution, give street and number) <b>SINAI HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE, MD</b>			9c. COUNTY OF DEATH				
RESIDENCE OF DECEDENT											
10a. STATE <b>MD</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTIMORE, CITY</b>			10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				
10e. STREET AND NUMBER <b>6101 LOCH RAVEN BLVD. APT-204</b>				10f. ZIP CODE <b>21239</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>BALTIMORE PITTSBURG TRANSFER CO.</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY							
17. FATHER'S NAME (First, Middle, Last) <b>BENJAMIN Y. GUEST SR.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Eulala SUBER</b>							
19a. INFORMANT'S NAME (Type/Print) <b>LILLIAN GUEST</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6101 LOCH RAVEN BLVD./BALTIMORE, MD 21239</b>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>KING MEMORIAL PARK</b>		20c. LOCATION — City or Town, State <b>RANDALLSTOWN, MD</b>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Bladys Warner</b>				22. NAME AND ADDRESS OF FACILITY <b>WM.C. MARCH F.H. 1101 E. NORTH AVE.</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>BRAIN STEM INFARCT</b> DUE TO (OR AS A CONSEQUENCE OF): <b>HYPER TENSION</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. b. c. d.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>old cerebrovascular accident</b>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>M.B.B.S.</b>		29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>3/2/91</b>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>SINAI HOSPITAL OF BALTIMORE</b>											
31. DATE FILED (Month, Day, Year) <b>3/MAR 87 1991</b>		32. REGISTRAR'S SIGNATURE <b>VINCENT K. K. TAM</b>									





91 05910

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>John R. Green SR.</b>				2. DATE OF DEATH MONTH DAY YEAR <b>3 - 5 - 91</b>		3. TIME OF DEATH <b>3:00 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>577 12 6422</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>78</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>5-12-12</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Loch Raven Veterans Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH		9c. COUNTY OF DEATH	
10a. STATE <b>MD</b>				10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTIMORE, CITY</b>	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>709 N. MONTFORD AVE.</b>		10f. ZIP CODE <b>21205</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>ARMY</b>	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5th</b> College (1-4 or 5+) <b>LABORER</b>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>LABORER</b>				16b. KIND OF BUSINESS/INDUSTRY		17. FATHER'S NAME (First, Middle, Last) <b>JAMES LOVE GREEN</b>	
18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MARY REGINA BUTLER</b>				19a. INFORMANT'S NAME (Type/Print) <b>GAIL MARSHALL</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>709 N. MONTFORD AVE./BALTIMORE, MD 21205</b>	
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>CROWNSVILLE VET. CEMETERY</b>		20c. LOCATION — City or Town, State <b>CROWNSVILLE, MD.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Gladys Wanner</b>				22. NAME AND ADDRESS OF FACILITY <b>WM.C. MARCH F.H. 1101 E. NORTH AVE.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Uroscapais</b> DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <b>Chronic Renal Abscesses</b> DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Cerebellar Degeneration</b> <b>Seizure disorder</b> <b>Recurrent Epistaxis</b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) <b>3/5/91</b>		28b. TIME OF INJURY <b>3:00 PM</b>	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Courtney W. Houshman MD</b>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) ▶	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Loch Raven Veterans Administration Hospital</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 07 1991</b>				32. REGISTRAR'S SIGNATURE <b>John R. Green</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91-1168-510

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 91 05911

1. DECEDENT'S NAME (First, Middle, Last) <b>James Lewis Gough</b>				2. DATE OF DEATH MONTH <b>03</b> DAY <b>02</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>11:56 A M</b>	
4. SOCIAL SECURITY NUMBER <b>216-36-0711</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>52</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>11-17-38</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Johns Hopkins Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>		9c. COUNTY OF DEATH <b>MD</b>	
10a. STATE <b>MD</b>		10b. COUNTY <b>BALTIMORE</b>		10c. CITY, TOWN OR LOCATION <b>CITY</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>907 MONTFORD AVE.</b>				10f. ZIP CODE <b>21205</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>N/A</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>CONSTRUCTION</b>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>Unknown</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Unknown</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MARY GOUGH</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>444 N. LUZERNE AVE. /BALTIMORE, MD. 21224</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>MT. CALVARY CEMETERY</b>		DATE		20c. LOCATION — City or Town, State <b>ANNE ARUNDEL CO, MD.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Bladys Women</b>				22. NAME AND ADDRESS OF FACILITY <b>WM.C. MARCH F.H. 1101 E. NORTH AVE.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>Gunshot wound of chest</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Undetermined		28a. DATE OF INJURY (Month, Day, Year) <b>03 02 1991</b>		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED <b>Subject shot</b>		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>At home</b>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>907 Montford Avenue</b>	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>[Signature]</b>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>03 02 1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Ann - Dixon 11 - PENN ST.</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 07 1991</b>				32. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020


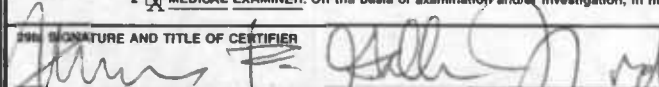

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Items: part 1, 23, 27, 28a, c, d, e, & f  
 1 - FOR STATE REGISTRAR REF 6-675  
 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH  
 REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Leonard M. Gardner III</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>4</b> YEAR <b>91</b>		3. TIME OF DEATH <b>1020 A M</b>	
4. SOCIAL SECURITY NUMBER		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) YRS. <b>6</b> MONTHS <b>6</b> DAYS <b>6</b> HOURS <b>6</b> MIN.		7. DATE OF BIRTH (Month, Day, Year) <b>8-5-1990</b>		8. BIRTHPLACE (State or Foreign Country) <b>Md</b>
9a. FACILITY NAME (If not institution, give street and number) <b>Maryland General Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH	
10a. STATE <b>Md</b>				10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>1343 Division Street</b>		10f. ZIP CODE <b>21217</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>				11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <b>Leonard M. Gardner, Jr</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Tina T. Doresy</b>			
19a. INFORMANT'S NAME (Type/Print)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1348 Division Street Baltimore, Md 21217</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Western Star Cemetery</b>		20c. LOCATION — City or Town, State <b>Catonsville, Md</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>March F/H West 4300 Wabash Avenue</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Obstruction of airway</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) <b>3-4-91</b>		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURED <b>Found with plastic bag over head</b>			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>Home</b>				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>1343 Division St.</b>			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/4/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MARLO F. GOUSS JR. MD 111 Penn St. Baltimore, Md</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 07 1991</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				91 05913							
1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH				3. TIME OF DEATH							
HYMAN GOLD (HYMAN GOLD)				MARCH 3 1991				6:10 A M							
4. SOCIAL SECURITY NUMBER		5. SEX		6. AGE (In yrs. last birthday)		7. DATE OF BIRTH		8. BIRTHPLACE (State or Foreign Country)							
063-14-8752		1 M 2 F		70 YRS.		APRIL 29, 1920		NEW YORK							
9a. FACILITY NAME (If not institution, give street and number)				9b. CITY, TOWN OR LOCATION OF DEATH				9c. COUNTY OF DEATH							
LEVINDALE				BALTIMORE											
10a. STATE				10b. COUNTY		10c. CITY, TOWN OR LOCATION		10d. INSIDE CITY LIMITS?							
MARYLAND				BALTIMORE		RANDALLSTOWN		1 YES 2 NO							
10a. STREET AND NUMBER				10f. ZIP CODE				10g. CITIZEN OF WHAT COUNTRY?							
3600 ANNE HATHAWAY DR., APT. 2-A				21133				USA							
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES?		13. WAS DECEDENT OF HISPANIC ORIGIN?		14. RACE — American Indian, Black, White, etc.									
1 Never Married 2 Married 3 Widowed 4 Divorced		X YES 2 NO IF YES, GIVE WAR OR DATES		1 YES X NO Specify:		Specify: WHITE									
15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY											
Elementary/Secondary (0-12) College (1-4 or 5+)		ACCOUNTANT		KORVETTE'S DEPT. STORE											
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)											
WILLIAM GOLDBERG				IDA UNKNOWN											
19a. INFORMANT'S NAME (Type/Print)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)											
ROBERT F. GOLD				P.O. BOX 492 ROSS, CA 94957											
20a. METHOD OF DISPOSITION		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)		20c. LOCATION — City or Town, State											
1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		MT. ZION		3/6/91		MASPETH, QUEENS, NY									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE				22. NAME AND ADDRESS OF FACILITY											
[Signature]				SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD., BALTO., MD 21215											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →															
a. CONGESTIVE HEART FAILURE															
DUE TO (OR AS A CONSEQUENCE OF):															
b. DUE TO (OR AS A CONSEQUENCE OF):															
c. DUE TO (OR AS A CONSEQUENCE OF):															
d. DUE TO (OR AS A CONSEQUENCE OF):															
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.															
24a. WAS AN AUTOPSY PERFORMED?								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?							
1 YES 2 NO								1 YES 2 NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER?				26. PLACE OF DEATH (Check only one)											
1 YES 2 NO				HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)											
27. MANNER OF DEATH				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK?		28d. DESCRIBE HOW INJURY OCCURRED					
1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined						M		1 YES 2 NO							
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one)				29b. SIGNATURE AND TITLE OF CERTIFIER								29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year)	
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				[Signature]								D17037		3/3/91	
2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)				31. DATE FILED (Month, Day, Year)								32. REGISTRAR'S SIGNATURE			
ESTRELLITA O. Kim, MD - LEVINDALE HEBREW GERIATRIC CENTER & HOSPITAL				MAR 7 1991								Julia Davidson-Randall		2.2.5	





**STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH**

REG. NO. **91 05914**

1 - FOR  
STATE  
REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last) <b>Rose C. Granger</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>5</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>M</b>	
4. SOCIAL SECURITY NUMBER <b>217-03-2973</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>74</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>12/26/1916</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>1611 S.Charles St.</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Balto.City,Md.</b>	
9c. COUNTY OF DEATH <b>-----</b>							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>-----</b>		10c. CITY, TOWN OR LOCATION <b>Balto.City,Md.</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1611 S.Charles St.</b>				10f. ZIP CODE <b>21230</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9th.Grade</b> College (14 or 5+) <b>-----</b>		18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		18b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>George ----- Egan</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary ----- Clark</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mr.Herman J.Granger</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1611 S.Charles St.Balto.Md.21230</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Glen Haven Memorial Park</b>		20c. LOCATION — City or Town, State <b>Glen Burnie,Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>► Daniel A. Taylor</b>				22. NAME AND ADDRESS OF FACILITY <b>130 E.Fort Ave. McCully Funeral Home, 130 E.Fort Ave.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Squamous Carcinoma of right lung</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  Approximate interval between Onset and Death <b>3.5 yrs.</b>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Alan M. Berkman MD</b>				29c. LICENSE NUMBER <b>022782</b>		29d. DATE SIGNED (Month, Day, Year) <b>► 3/6/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Arnon W Berkman MD Harbor Hospital Center</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 07 1991</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 05915

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Charles H. Gordon</b>				2. DATE OF DEATH MONTH DAY YEAR <b>Mar 6, 1991</b>		3. TIME OF DEATH <b>6:30 A M</b>	
4. SOCIAL SECURITY NUMBER <b>213-03-3889</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>71</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>1-23-19</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>St. Joseph Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Towson</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
10a. STATE <b>Md.</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Balto.</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>6218 The Alameda</b>				10f. ZIP CODE <b>21239</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Ororced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>W.W. II</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Bur. of Transportation</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Balto. City</b>			
17. FATHER'S NAME (First, Middle, Last) <b>James E. Gordon</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Margaret McBride</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Maeanna E. Gordon</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6218 The Alameda Balto., Md. 21239</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Parkwood Cem. 3-9-91</b>		20c. LOCATION — City or Town, State <b>Balto., Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>John C. Miller Inc. 6415 Belair Rd. Balto., Md. 21206</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Anoxic Brain Damage</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. <b>History Cardiopulm. arrest</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>ASCVD</b> DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death <b>3 D.</b> <b>3 D.</b> <b>YRS.</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>3/6/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>St. Joseph's Hosp.</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 7 1991</b>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				CERTIFICATE OF DEATH				REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last) <i>Virginia Ruth Hampton</i>				2. DATE OF DEATH MONTH <i>3</i> DAY <i>3</i> YEAR <i>91</i>				3. TIME OF DEATH <i>2:43 P.M.</i>							
4. SOCIAL SECURITY NUMBER <i>226-46-6912</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>55</i> YRS.		IF UNDER 1 YEAR MONTHS <i>55</i> DAYS <i>55</i>		IF UNDER 24 HRS. HOURS <i>55</i> MIN. <i>55</i>		7. DATE OF BIRTH (Month, Day, Year) <i>4 27 35</i>		8. BIRTHPLACE (State or Foreign Country) <i>VA</i>			
9a. FACILITY NAME (If not institution, give street and number) <i>Stella Maris Hospice</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>TOWSON</i>				9c. COUNTY OF DEATH <i>BALT.</i>							
10a. STATE <i>MD</i>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <i>TOWSON</i>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER <i>482 CUMBERLAND CT.</i>				10f. ZIP CODE <i>21201</i>				10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>							
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <i>BLACK</i>							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12TH</i> College (13-16) <i>College (13-16)</i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>UNEMPLOYED</i>				16b. KIND OF BUSINESS/INDUSTRY							
17. FATHER'S NAME (First, Middle, Last) <i>JOHNNIE WOODLEY</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>MOLLIE WILLIAMS</i>											
19a. INFORMANT'S NAME (Type/Print) <i>SAMUEL HAMPTON</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>5911 DAYWALT AVE./BALTIMORE, MD. 21206</i>											
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <i>MASON GROVE CH. CEMETERY</i>		20c. LOCATION — City or Town, State <i>VALENTINE, VA.</i>											
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Gladys Wanner</i>				22. NAME AND ADDRESS OF FACILITY <i>WM.C. MARCH F.H. 1101 E. NORTH AVE</i>											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Breast cancer</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <i>Hospice</i>		26. PLACE OF DEATH (Check only one)									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <i>1</i> YES <input type="checkbox"/> NO <input type="checkbox"/>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>		28d. DESCRIBE HOW INJURY OCCURRED							
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)													
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Carla A. Alexander MD</i>				29c. LICENSE NUMBER <i>D27087</i>		29d. DATE SIGNED (Month, Day, Year) <i>3-3-91</i>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>DR. CARLA ALEXANDER 2300 Dulany Valley Rd Towson, MD 21204</i>															
31. DATE FILED (Month, Day, Year) <i>MAR 07 1991</i>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson</i>											



REG. NO.

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

Vascular Coagulation

X

1 2nd



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

91 05918

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JAMES HOLLY</b>				2. DATE OF DEATH MONTH <b>02</b> DAY <b>24</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>3:24 P M</b>	
4. SOCIAL SECURITY NUMBER <b>219-01-8887</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>75</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>4-12-15</b>	
8. FACILITY NAME (If not institution, give street and number) <b>1912 WEST FAIRMOUNT AVENUE</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>		9c. COUNTY OF DEATH	
10a. STATE <b>Md.</b>				10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
10e. STREET AND NUMBER <b>1912 W. Fairmount Ave.</b>				10f. ZIP CODE <b>21223</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Laborer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Manufacturing</b>			
17. FATHER'S NAME (First, Middle, Last) <b>James Harris</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Emma Harris</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Larry Haskins</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3101 Yolando Rd. Balto., Md. 21218</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Mt. Zion Cemetery</b>		20c. DATE		20d. LOCATION — City or Town, State <b>Balto. Cnty., Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Irvin Carroll</i>				22. NAME AND ADDRESS OF FACILITY <b>Irvin Carroll F/H 1712-14 W. North Ave. Balto., md. 21217</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Arteriosclerotic cardiovascular disease</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)	
28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
30. SIGNATURE AND TITLE OF CERTIFIER <i>John F. Galt Jr. MD</i>				29c. LICENSE NUMBER <b>OCME</b>		29d. DATE SIGNED (Month, Day, Year) <b>02 25 1991</b>	
31. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MARIO F. GOLDS JR., MD. 111 PENN STREET BALTIMORE, MARYLAND 21201</b>							
32. DATE FILED (Month, Day, Year) <b>MAR 07 1991</b>				32. REGISTRAR'S SIGNATURE <i>John Davidson-Wardell</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE		91 05919	
CERTIFICATE OF DEATH		REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last) <b>Margaret Naomi Hieber</b>		2. DATE OF DEATH MONTH <b>3</b> DAY <b>3</b> YEAR <b>91</b>		3. TIME OF DEATH <b>3 P. M.</b>	
4. SOCIAL SECURITY NUMBER <b>219-20-7984</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>79</b> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <b>7/30/94</b>		8. BIRTHPLACE (State or Foreign Country) <b>Balto. MD</b>		9. COUNTY OF DEATH <b>Md. Baltimore</b>	
10a. STATE <b>MD</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Towson</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>7001 N. Charles St.</b>		10f. ZIP CODE <b>21204</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>N/A</b>		17. FATHER'S NAME (First, Middle, Last) <b>Andrew Salloway</b>	
18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Bassett</b>		19a. INFORMANT'S NAME (Type/Print) <b>Gloria Reed</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>890 38th Ave. Santa Cruz California 95062</b>	
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Greenmount Cemetery</b>		20c. LOCATION — City or Town, State <b>Baltimore Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Dennis S. Xenakis</b>		22. NAME AND ADDRESS OF FACILITY <b>Mitchell-Wiedefeld Home 6500 York Road Baltimore, Maryland 21212</b>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Pneumonia</b>  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF): <b>Stasis</b>  b. DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d.  Approximate Interval Between Onset and Death <b>24 hrs</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Dementia, Malnutrition, Decubitus presacral ulcer</b>		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)		28f. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>William Benson, Jr.</b>		29c. LICENSE NUMBER <b>DO 4236</b>	
29d. DATE SIGNED (Month, Day, Year) <b>3/3/91</b>		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>WILLIAM BENSON 3506 N. CALVERT ST. BALT., MD, 21218</b>		31. DATE FILED (Month, Day, Year) <b>MAR 07 1991</b>	
32. REGISTRAR'S SIGNATURE <b>J. Davidson</b>					



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>NORMAN LEROY HANCOCK</b>		2. DATE OF DEATH MONTH <b>03</b> DAY <b>02</b> YEAR <b>91</b>		3. TIME OF DEATH <b>12:51 A M</b>	
4. SOCIAL SECURITY NUMBER <b>227 44 2091</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>56</b> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <b>Feb. 28, 1935</b>		8. BIRTHPLACE (State or Foreign Country) <b>Washington D.C.</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>DORSEY ROAD NEAR SHIPLEY AVENUE</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>HARMONS</b>		9c. COUNTY OF DEATH <b>ANNE ARUNDEL</b>	
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>ANNE ARUNDEL</b>		10c. CITY, TOWN OR LOCATION <b>PASADENA</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>771 WILLOWBY RUN</b>		10f. ZIP CODE <b>21122</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>Korean Conflict</b>	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>CAUCASION</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b></b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Purchasing Agent</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Meat Company</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Richar E. Hancock</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Gladys Barrett</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Ellen M. Sutherland</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>771 Willowby Run, Pasadena, Maryland 21122</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Maryland Veterans Cemetery 3/5/91</b>		20c. LOCATION — City or Town, State <b>Crownsville, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY <b>McCully Funeral Home of Pasadena 3204 Mountain Rd., Pasadena, MD 21122</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.		Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b></b>		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED <b></b>		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b></b>	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER <b>O.C.M.E.</b>	
29d. DATE SIGNED (Month, Day, Year) <b>03/03/91</b>		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>A.M. DIXON 111 PENN STREET, BALTIMORE, MARYLAND 21201</b>			
31. DATE FILED (Month, Day, Year) <b>MAR 07 1991</b>		32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

91 05921

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>WILLIAM George Horstman</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>4</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>8:54 P M</b>	
4. SOCIAL SECURITY NUMBER <b>215-12-9229</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>68</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>May 25, 1922</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Harbor Hospital Center</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>	
9c. COUNTY OF DEATH <b>City</b>				10a. STATE <b>MD</b>		10b. COUNTY <b>Anne Arundel</b>	
10c. CITY, TOWN OR LOCATION <b>Linthicum</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>541 Shipley Rd.</b>	
10f. ZIP CODE <b>21090</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>W.W. II</b>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>None</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Inspector</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Koppers Co.</b>	
17. FATHER'S NAME (First, Middle, Last) <b>William Horstman</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Elizabeth A. Greason</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Dorothy K. Horstman</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Same As # 10</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Meadowridge Memorial Park 3-7</b>		20c. LOCATION — City or Town, State <b>Elkridge, Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Singleton Funeral Home</b> <b>1 Second Ave. S.W. Glen Burnie, Md. 21061</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>END STAGE CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>BOWEL OBSTRUCTION 2' TO ADHESIONS.</b> <b>CARDIOMEGALY.</b> <b>ADENOCARCINOMA OF SIGMOID COLON.</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>INTERN</b>				29c. LICENSE NUMBER <b>AS 24416 14-15</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/4/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>ANVERA HALLI M HARISH. HARBOR HOSPITAL CENTER</b> <b>SOUTH HANOVER STREET BALTIMORE MARYLAND</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 7 1991</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146  
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





91 05922

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Elizabeth C. Harryman</i>				2. DATE OF DEATH MONTH <i>3</i> DAY <i>4</i> YEAR <i>91</i>		3. TIME OF DEATH <i>1105 PM</i>	
4. SOCIAL SECURITY NUMBER <i>216 46 2548</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <i>89</i> YRS.	7. DATE OF BIRTH (Month, Day, Year) <i>1/10/02</i>		8. BIRTHPLACE (State or Foreign Country) <i>Maryland</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Church Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i>		9c. COUNTY OF DEATH	
10a. STATE <i>Md</i>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <i>Baltimore</i>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <i>101 N. Bond St</i>				10f. ZIP CODE <i>21231</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>College</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Homemaker</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Own Home</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Douglas C. Turnbull</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Elizabeth Brogden</i>			
19a. INFORMANT'S NAME (Type/Print) <i>George Harryman, 3rd</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>RD#1, Box 80, Delta, Pa. 17314</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Harryman Cemetery 3/7/91</i>		20c. LOCATION — City or Town, State <i>Timonium, Md.</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Wallace S. Brooks Jr.</i>				22. NAME AND ADDRESS OF FACILITY <i>Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, Md. 21204</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. Cardiopulmonary Arrest</i>							<i>3 min.</i>
DUE TO (OR AS A CONSEQUENCE OF):							
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>b. Hypertensive heart disease</i>							
DUE TO (OR AS A CONSEQUENCE OF):							
<i>c. Hypertension</i>							
DUE TO (OR AS A CONSEQUENCE OF):							
<i>d.</i>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Thoracic Aortic dissection</i>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURED		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <i>Baltimore Md</i>			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Susan K. Ferrand</i>		29c. LICENSE NUMBER <i>D35070</i>		29d. DATE SIGNED (Month, Day, Year) <i>3/5/91</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Susan K. Ferrand 100 N. BROADWAY BALTIMORE, MD 21231</i>							
31. DATE FILED (Month, Day, Year) <i>MAR 07 1991</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 05923

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) BABY BOY A BARNES / DESHAWN JAMES				2. DATE OF DEATH MONTH 03 DAY 01 YEAR 1991		3. TIME OF DEATH 7:45 P M	
4. SOCIAL SECURITY NUMBER N/A		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) YRS.		7. DATE OF BIRTH (Month, Day, Year) 02-28-91	
8. BIRTHPLACE (State or Foreign Country) MD				9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH BALITMORE CITY	
10a. STATE MD				10b. COUNTY		10c. CITY, TOWN OR LOCATION BALTIMORE, CITY	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 1200 N. BRADFORD STREET		10f. ZIP CODE 21213	
10g. CITIZEN OF WHAT COUNTRY? USA				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: BLACK		15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) CHILD College (1-4 or 5+) CHILD	
16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CHILD				16b. KIND OF BUSINESS/INDUSTRY		17. FATHER'S NAME (First, Middle, Last) WILLIE JAMES	
18. MOTHER'S NAME (First, Middle, Maiden Surname) WANDA BARNES				19a. INFORMANT'S NAME (Type/Print) WANDA BARNES		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1200 N. BRADFORD ST./BALTIMORE, MD. 21213	
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) VOSHALL MEMORIAL GARDENS		20c. LOCATION — City or Town, State BALTIMORE, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Bladine Warren				22. NAME AND ADDRESS OF FACILITY WM.C. MARCH F.H 1101 E. NORTH AVE.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Prematurity 23 weeks DUE TO (OR AS A CONSEQUENCE OF): b. Pulmonary Hemorrhage DUE TO (OR AS A CONSEQUENCE OF): c. Intracranial Hemorrhage DUE TO (OR AS A CONSEQUENCE OF): d. Cardiorespiratory Arrest Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) None		28b. TIME OF INJURY None	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				28d. DESCRIBE NOW INJURY OCCURRED None		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) None	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) None				29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER C. Shields MD				29c. LICENSE NUMBER A95-28		29d. DATE SIGNED (Month, Day, Year) 3-1-91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Johns Hopkins Hospital N/A							
31. DATE FILED (Month, Day, Year) MAR 07 1991				32. REGISTRAR'S SIGNATURE Johna Davidson-Randall			

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEASED'S NAME (First, Middle, Last)				2. DATE OF DEATH MONTH DAY YEAR				3. TIME OF DEATH HOURS MIN			
BABY BOY B BARNES / LASHAWN JAMES				03 2 1991				2:30 A M			
4. SOCIAL SECURITY NUMBER N/A		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) YRS. MONTHS DAYS 2		7. DATE OF BIRTH (Month, Day, Year) 02-28-91		8. BIRTHPLACE (State or Foreign Country) MD			
9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE				9c. COUNTY OF DEATH BALTIMORE CITY			
10a. STATE MD		10b. COUNTY		10c. CITY, TOWN OR LOCATION BALTIMORE, CITY				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER 1200 N. BRADFORD STREET				10f. ZIP CODE 21213		10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) CHILD College (1-4 or 5+) CHILD		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CHILD		16b. KIND OF BUSINESS/INDUSTRY							
17. FATHER'S NAME (First, Middle, Last) WILLIE JAMES				18. MOTHER'S NAME (First, Middle, Maiden Surname) WANDA BARNES							
19a. INFORMANT'S NAME (Type/Print) WANDA BARNES				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1200 N. BRADFORD ST./BALTIMORE, MD 21213							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) VOSHILL MEMORIAL GARDENS		20c. LOCATION — City or Town, State BALTIMORE, MD							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Bladine Wanner				22. NAME AND ADDRESS OF FACILITY WM.C. MARCH F.H. 1101 E. NORTH AVE							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Prematurity 23 wks DUE TO (OR AS A CONSEQUENCE OF): b. Pulmonary Hemorrhage DUE TO (OR AS A CONSEQUENCE OF): c. Intracranial Hemorrhage DUE TO (OR AS A CONSEQUENCE OF): d. Cardiorespiratory Arrest Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death 2d 1d 2d			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) None		28b. TIME OF INJURY None		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED None			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER C. Sherb MD				29c. LICENSE NUMBER A9528		29d. DATE SIGNED (Month, Day, Year) 3/2/91			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)											
31. DATE FILED (Month, Day, Year) MAR 07 1991				32. REGISTRAR'S SIGNATURE Randall							



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				CERTIFICATE OF DEATH				REG. NO. 91 05925					
1. DECEASED'S NAME (First, Middle, Last) <b>ROYSTON LEE JACKSON</b>						2. DATE OF DEATH MONTH <b>03</b> DAY <b>03</b> YEAR <b>91</b>				3. TIME OF DEATH <b>0614</b> M							
4. SOCIAL SECURITY NUMBER <b>216-54 6685</b>			5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		8. AGE (In yrs. last birthday) <b>39</b> YRS.		IF UNDER 1 YEAR MONTHS <b>03</b> DAYS <b>03</b>		IF UNDER 24 HRS. HOURS <b>06</b> MIN. <b>14</b>		7. DATE OF BIRTH (Month, Day, Year) <b>6-27-50</b>		8. BIRTHPLACE (State or Foreign Country) <b>Md.</b>				
9a. FACILITY NAME (If not institution, give street and number) <b>606 E. Patrick ST.</b>						9b. CITY, TOWN OR LOCATION OF DEATH <b>Frederick</b>						9c. COUNTY OF DEATH					
RESIDENCE OF DECEASED				10a. STATE <b>Md.</b>				10b. COUNTY				10c. CITY, TOWN OR LOCATION <b>Frederick</b>					
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>606 E. Patrick ST.</b>				10f. ZIP CODE <b>21701</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>								
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>				16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Clerical</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Dunhill Services</b>									
17. FATHER'S NAME (First, Middle, Last) <b>William Johnson</b>						18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Gertrude Jackson</b>											
19a. INFORMANT'S NAME (Type/Print) <b>Patricia Harris</b>						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1014 Waterside CT. Edgewood 21040</b>											
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metro Crematory</b>			20c. LOCATION — City or Town, State <b>Beth. Md.</b>											
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>James A. Morton</b>						22. NAME AND ADDRESS OF FACILITY <b>James A. Morton &amp; Sons 1701 Laurens ST. Belts, Md. 21217</b>											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST												Approximate Interval Between Onset and Death					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO			24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)													
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED							
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)													
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																	
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Robert R R Roberts MD</b>										29c. LICENSE NUMBER <b>D09867</b>			29d. DATE SIGNED (Month, Day, Year) <b>03/03/91</b>				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>RRR ROBERTS MD 15 W 7TH ST Frederick Md 21701</b>																	
31. DATE FILED (Month, Day, Year) <b>MAR 07 1991</b>					32. REGISTRAR'S SIGNATURE <b>Julia Davidson Randall</b>												





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH				3. TIME OF DEATH							
Linda Jackson				3 2 1991				M							
4. SOCIAL SECURITY NUMBER		5. SEX		8. AGE (In yrs. last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		7. DATE OF BIRTH		6. BIRTHPLACE (State or Foreign Country)			
213-54-0526		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		43 YRS.		MONTHS DAYS		HOURS MIN.		1-16-1948		Md			
9a. FACILITY NAME (If not institution, give street and number)								9b. CITY, TOWN OR LOCATION OF DEATH				9c. COUNTY OF DEATH			
3600 W. Franklin Street								Baltimore							
10a. STATE				10b. COUNTY				10c. CITY, TOWN OR LOCATION				10d. INSIDE CITY LIMITS?			
Md								Baltimore				1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER								10f. ZIP CODE				10g. CITIZEN OF WHAT COUNTRY?			
3600 W. Franklin Street								21229				U S A			
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES?		13. WAS DECEDENT OF HISPANIC ORIGIN?		14. RACE — American Indian, Black, White, etc.									
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		Specify: Black									
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		IF YES, GIVE WAR OR DATES		Specify:											
15. DECEDENT'S EDUCATION (Specify only highest grade completed)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY							
Elementary/Secondary (0-12) 12th				College (1-4 or 5 +)				School System							
17. FATHER'S NAME (First, Middle, Last)								18. MOTHER'S NAME (First, Middle, Maiden Surname)							
Robert Carter								Myrtice Howard							
19a. INFORMANT'S NAME (Type/Print)								19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)							
Myrtice Carter								3600 W. Franklin Street Baltimore, Md 21229							
20a. METHOD OF DISPOSITION				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place)				DATE		20c. LOCATION — City or Town, State					
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				King Memorial Park						Randallstown, Md					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE								22. NAME AND ADDRESS OF FACILITY							
Myrtice Carter								March F/H West 4300 Wabash Avenue							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate interval Between Onset and Death			
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Metastatic breast cancer												7 yrs			
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST															
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.															
24a. WAS AN AUTOPSY PERFORMED?												24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO												1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER?				26. PLACE OF DEATH (Check only one)											
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK?		28d. DESCRIBE HOW INJURY OCCURRED					
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined						M		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
				28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one)												29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year)	
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												D18587		3/4/91	
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER								29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year)					
Paul Gormley MD								D18587		3/4/91					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)															
Paul Gormley 900 Baton Ave Balt MD 21229															
31. DATE FILED (Month, Day, Year)				32. REGISTRAR'S SIGNATURE											
MAR 07 1991				Julia Davidson-Randall											



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05927

1. DECEDENT'S NAME (First, Middle, Last) <b>Jerry Kelly</b>		2. DATE OF DEATH MONTH <b>5</b> DAY <b>28</b> YEAR <b>91</b>		3. TIME OF DEATH <b>6:15 AM</b> M	
4. SOCIAL SECURITY NUMBER <b>158-52-5241</b>		5. SEX <b>MALE</b>		6. AGE (In yrs. last birthday) <b>48</b> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <b>11-28-41</b>		8. BIRTHPLACE (State or Foreign Country) <b>VA.</b>		9. COUNTY OF DEATH <b>Maryland</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>	
10d. INSIDE CITY LIMITS? <b>1</b> YES <b>2</b> NO		10e. STREET AND NUMBER <b>Hartford Gardens N.H.</b>		10f. ZIP CODE <b>21214</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <b>1</b> Never Married <b>2</b> Married <b>3</b> Widowed <b>4</b> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> YES <b>2</b> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> YES <b>2</b> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>College (1-4 or 5 +)</b>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>painter</b>		16b. KIND OF BUSINESS/INDUSTRY		17. FATHER'S NAME (First, Middle, Last) <b>Unknown</b>	
18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Unknown</b>		19a. INFORMANT'S NAME (Type/Print) <b>Gail Graves</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2525 W. Belvedere Ave Baltimore Md 21215</b>	
20a. METHOD OF DISPOSITION <b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>MT Zion Cemetery Baltimore Md</b>		20c. LOCATION — City or Town, State <b>Baltimore Md</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Kevin Carroll</b>		22. NAME AND ADDRESS OF FACILITY <b>Irvin Carroll FTH 1712 W. North Ave. Baltimore, Md 21217</b>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Hepatic Coma</b> DUE TO (OR AS A CONSEQUENCE OF): <b>End Stage Cirrhosis and</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Renal Failure</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	
24a. WAS AN AUTOPSY PERFORMED? <b>1</b> YES <b>2</b> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1</b> YES <b>2</b> NO		25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> YES <b>2</b> NO	
26. PLACE OF DEATH (Check only one) <b>HOSPITAL:</b> <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA <b>OTHER:</b> <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify)		27. MANNER OF DEATH <b>1</b> Natural <b>5</b> Pending Investigation <b>2</b> Accident <b>6</b> Could not be determined <b>3</b> Suicide <b>4</b> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>3/6/91</b>	
28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1</b> YES <b>2</b> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) <b>1</b> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Ronald Pachuta</b>		29c. LICENSE NUMBER <b>D09752</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/6/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Donald M Pachuta 2735 N Charles St Baltimore Md</b>					
31. DATE FILED (Month, Day, Year) <b>3/6 MAR 07 1991</b>		32. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>			



ITEMS: 23 thru 28f per ME  
G-673 3/22/91 cm  
91-1154-510

91 05928

1 FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Kenneth M. Lampkin</b>				2. DATE OF DEATH MONTH <b>03</b> DAY <b>01</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>3:59 P M</b>	
4. SOCIAL SECURITY NUMBER <b>218-44-7035</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>44</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>10-7-46</b>	
8. BIRTHPLACE (State or Foreign Country) <b>MD.</b>				9a. FACILITY NAME (If not institution, give street and number) <b>5626 Loch Raven Blvd. Apt A</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>	
9c. COUNTY OF DEATH <b>MD</b>				10a. STATE <b>MD</b>		10b. COUNTY <b>Baltimore</b>	
10c. CITY, TOWN OR LOCATION <b>Baltimore</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>5626 LOCH RAVEN BLVD. APT. A</b>	
10f. ZIP CODE <b>21239</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify:				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>Elementary</b> College (1-4 or 5+) <b>College</b>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>MAINTENANCE</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Public</b>			
17. FATHER'S NAME (First, Middle, Last) <b>THOMAS LAMPKIN</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>GWENDOLYN HARRINGTON</b>			
19a. INFORMANT'S NAME (Type/Print) <b>GWENDOLYN LAWS</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5626 LOCH RAVEN BLVD. BALTO. MD. 21239</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>MT. CALVARY CMTY. 3691 R.R. Co., MD.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Randolph J. Collick</b>				22. NAME AND ADDRESS OF FACILITY <b>2431 E. Oliver St. BALTO., MD. 21213</b>			
23. PART I. Enter the disease or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. NARCOTIC INTOXICATION</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequently flat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  b. DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) <b>FOUND: 3/1/91</b> 28b. TIME OF INJURY <b>UNKNOWN</b> 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 28d. DESCRIBE HOW INJURY OCCURRED <b>SUBJECT INGESTED DRUGS</b>			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>HOME</b>				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>5626 LOCH RAVEN BLVD BALTIMORE, MARYLAND</b>			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>[Signature]</b>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>03 02 1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>ANDERSON 111 Penn Street, Baltimore, Maryland 21201</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 07 1991</b>				32. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 059223

1. DECEDENT'S NAME (First, Middle, Last) <b>JOSEPH LEVINE</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>31</b> YEAR <b>91</b>		3. TIME OF DEATH <b>1433</b> M	
4. SOCIAL SECURITY NUMBER <b>577 40 0794</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>80</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>12/14/10</b>		8. BIRTHPLACE (State or Foreign Country) <b>New York</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Holy Cross Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Silver Spring</b>		9c. COUNTY OF DEATH <b>Montgomery</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Silver Spring</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>8811 Colesville Rd.</b>				10f. ZIP CODE <b>20910</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5+</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Chemist</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Food and Drug Administration</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Philip Levine</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Ethel Rosenberg</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Irene Bratman Levine</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Same as #10</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>King David Memorial Gdn.</b>		20c. LOCATION — City or Town, State <b>Falls Church, Va.</b>		DATE <b>3-5</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>Ives-Pearson Funeral Homes Arlington, Va. 22201</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acute leukemia</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. b. c. d.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Arteriosclerotic heart disease</b>							Approximate Interval Between Onset and Death <b>6 mo</b>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>D10690</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/31/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>ATTA GEORGIA ADE, SILVER SPRING</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 7 1991</b>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.







TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEASED'S NAME (First, Middle, Last)				2. DATE OF DEATH MONTH DAY YEAR				3. TIME OF DEATH					
Goldie Lesser				3-22-91				3:40P M					
4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHPLACE (State or Foreign Country)			
215-58-3720		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	96 YRS.	MONTHS DAYS		HOURS MIN.		7-01-'94		POLAND			
9a. FACILITY NAME (If not institution, give street and number)				9b. CITY, TOWN OR LOCATION OF DEATH				9c. COUNTY OF DEATH					
Levindale				BALTIMORE City									
10a. STATE				10b. COUNTY				10c. CITY, TOWN OR LOCATION				10d. INSIDE CITY LIMITS?	
MARYLAND								BALTIMORE				1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER				10f. ZIP CODE				10g. CITIZEN OF WHAT COUNTRY?					
3433 REISTERSTOWN RD.				21215				USA					
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES?		13. WAS DECEDENT OF HISPANIC ORIGIN?		14. RACE — American Indian, Black, White, etc.							
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		Specify: WHITE							
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced													
15. DECEDENT'S EDUCATION (Specify only highest grade completed)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY					
Elementary/Secondary (0-12) College (1-4 or 5+)				HOUSEWIFE				AT HOME					
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)									
UNKNOWN ROTHSCHILD				UNKNOWN									
19a. INFORMANT'S NAME (Type/Print)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)									
MR. JESSE LESSER				9 POMONA SOUTH, APT. 8 BALTIMORE, MD 21208									
20a. METHOD OF DISPOSITION				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)				20c. LOCATION — City or Town, State					
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State				PROGRESSIVE BENEFIT & SICK RELIEF 3/5/91				ROSEDALE, MD					
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)													
21. SIGNATURE OF FUNERAL SERVICE LICENSEE				22. NAME AND ADDRESS OF FACILITY									
Sydney I. Stillman				SOL LEVINSN & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death			
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE													
DUE TO (OR AS A CONSEQUENCE OF):													
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST													
b. DUE TO (OR AS A CONSEQUENCE OF):													
c. DUE TO (OR AS A CONSEQUENCE OF):													
d. DUE TO (OR AS A CONSEQUENCE OF):													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED?			
										1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
										24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
										1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER?				26. PLACE OF DEATH (Check only one)									
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK?		28d. DESCRIBE HOW INJURY OCCURRED			
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation						M		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
2 <input type="checkbox"/> Accident													
3 <input type="checkbox"/> Suicide													
4 <input type="checkbox"/> Homicide													
8 <input type="checkbox"/> Could not be determined													
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)										28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one)				29b. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUMBER				29d. DATE SIGNED (Month, Day, Year)					
Cecilia O. Kw. M.D.				217037				3/31/91					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)													
ESTRELLA O. Kw. M.D. - LEVINDALE HEBREW GERIATRIC CENTER & HOSPITAL													
31. DATE FILED (Month, Day, Year)				32. REGISTRAR'S SIGNATURE									
MAR 7 1991				John Davidson-Randall									



91 05931

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>FRANCES ROSE LEON</b>				2. DATE OF DEATH MONTH <b>3</b> - DAY <b>3</b> - YEAR <b>91</b>		3. TIME OF DEATH <b>8:30 P M</b>	
4. SOCIAL SECURITY NUMBER <b>220-12-7078</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>79</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>APR. 1, 1911</b>		8. BIRTHPLACE (State or Foreign Country) <b>PENNSYLVANIA</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>3516 LANGREHR RD., APT. 1-D</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		9c. COUNTY OF DEATH <b>BALTIMORE</b>	
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>BALTIMORE</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>3516 LANGREHR RD., APT. 1-D</b>				10f. ZIP CODE <b>21207</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOUSEWIFE</b>		16b. KIND OF BUSINESS/INDUSTRY <b>AT HOME</b>			
17. FATHER'S NAME (First, Middle, Last) <b>ISRAEL SVIDGALL</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>REBECCA BENNETT</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MRS. KARLEEN ZANDICK</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9904 CERVIDAE LA. RANDALLSTOWN, MD 21133</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>ANSHE EMUNAH 3/5/91</b>		20c. LOCATION — City or Town, State <b>BALTIMORE, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Ellen Levine</b>				22. NAME AND ADDRESS OF FACILITY <b>SOL LEVINSON &amp; BROS., INC. 6010 REISTERSTOWN RD. BALTIMORE, MD 21215</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acute myocardial infarction</b>  Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Hypertension Arteriosclerosis</b>  a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  28a. DATE OF INJURY (Month, Day, Year)  28b. TIME OF INJURY M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  28d. DESCRIBE HOW INJURY OCCURRED  28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. SIGNATURE AND TITLE OF CERTIFIER <b>M. J. Ellis</b>  29c. LICENSE NUMBER <b>003078</b>  29d. DATE SIGNED (Month, Day, Year) <b>3/4/91</b>  30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>M. J. Ellis 5310 O/D Cant Rd. Randallstown, MD</b>  31. DATE FILED (Month, Day, Year) <b>MAR 7 1991</b>  REGISTRAR'S SIGNATURE <b>Julia Davidson-Rodriguez</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



ITEM: 19a per FH  
G-673 3/14/91 cm

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05932

1. DECEDENT'S NAME (First, Middle, Last) <b>Rickey R. MALONE</b>		2. DATE OF DEATH MONTH <b>03</b> DAY <b>03</b> YEAR <b>91</b>		3. TIME OF DEATH <b>9:30 A M</b>	
4. SOCIAL SECURITY NUMBER <b>220-64-8472</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>35</b> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <b>10-13-55</b>		8. BIRTHPLACE (State or Foreign Country) <b>Md.</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Bon Secors</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Balto</b>		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT					
10a. STATE <b>Md.</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
10e. STREET AND NUMBER <b>515 N. Fulton Avenue</b>		10f. ZIP CODE <b>21223</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Janitorial</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Cleaning</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Robert Malone</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Bertha Malone</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Jean Marie Malone</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1712 Laurens St. Balto., Md. 21217</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Western Star</b>		20c. LOCATION — City or Town, State <b>Balto., Md/</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>James A. Morton</b>		22. NAME AND ADDRESS OF FACILITY <b>James A. Morton &amp; Sons</b> <b>1701 Laurens St. Balto., Md. 21217</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>PNEUMONIA</b> DUE TO (OR AS A CONSEQUENCE OF): a. <b>CANDIDA INFECTION</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>SEVERE SEPSIS</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>SEPSIS</b> DUE TO (OR AS A CONSEQUENCE OF): d. <b>SEPSIS</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST					Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Renal Failure</b>					24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <b>A. Sidler ATTENDING PHYSICIAN</b>		29c. LICENSE NUMBER <b>213 248</b>		29d. DATE SIGNED (Month, Day, Year) <b>3-4-91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>ASIA S. Sidler MD 500 BALTO. APTL. Bldg BALTO. Md 21229</b>					
31. DATE FILED (Month, Day, Year) <b>MAR 07 1991</b>		32. REGISTRAR'S SIGNATURE <b>Julia Anderson-Randall</b>			

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



ITEMS: 23, 27 per ME  
G-674 4/3/91 cm  
91-1138-033

91 05933

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Murphy Glenn Matthews		2. DATE OF DEATH MONTH DAY YEAR 02 28 1991		3. TIME OF DEATH 2:05 P M	
4. SOCIAL SECURITY NUMBER 452-64-3015		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 50 YRS.	
7. DATE OF BIRTH (Month, Day, Year) Oct. 28, 1940		8. BIRTHPLACE (State or Foreign Country) Houston, Tx			
9a. FACILITY NAME (If not institution, give street and number) 3107 Goodhope Avenue Apartment 606		9b. CITY, TOWN OR LOCATION OF DEATH Temple Hills		9c. COUNTY OF DEATH Prince Georges	
10a. STATE Md.		10b. COUNTY Prince George		10c. CITY, TOWN OR LOCATION Temple Hills,	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 3107 Goodhope Ave, Apt. 606		10f. ZIP CODE 20748	
10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Contract Specialist		16b. KIND OF BUSINESS/INDUSTRY Federal Government	
17. FATHER'S NAME (First, Middle, Last) Murphy Foster Matthews		18. MOTHER'S NAME (First, Middle, Maiden Surname) Rebecca Crawford Matthews			
19a. INFORMANT'S NAME (Type/Print) Carrie Reese		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 701 Mansfield Street, Houston, Tx. 77091			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Suburban Crematory 3/5/91		20c. LOCATION — City or Town, State Silver Springs, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Glenn A. Brook</i>		22. NAME AND ADDRESS OF FACILITY Morrow & Woodford Funeral Hm. 1622 11th St, N.W. Wash. D.C. 20001			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CARDIAC ARRHYTHMIA DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.		Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input checked="" type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>John F. Gole Jr. MD</i>		29c. LICENSE NUMBER O.C.M.E.	
29d. DATE SIGNED (Month, Day, Year) 03 01 1991		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ARLO F. GOLE JR. MD 111 Penn Street, Baltimore, Maryland 21201			
31. DATE FILED (Month, Day, Year) MAR 7 1991		32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH		3. TIME OF DEATH	
Anna L. McKay Anna Lenora McKay				3/4/91		8:45 M	
4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. last birthday)	7. DATE OF BIRTH		8. BIRTHPLACE (State or Foreign Country)	
577-09-1049		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	82 YRS.	7/29/08		Md.	
9a. FACILITY NAME (If not institution, give street and number)				9b. CITY, TOWN OR LOCATION OF DEATH		9c. COUNTY OF DEATH	
Deaton Hosp. Medical Center				Balto		Md. N/A	
10a. STATE		10b. COUNTY		10c. CITY, TOWN OR LOCATION		10d. INSIDE CITY LIMITS?	
Maryland		N/A		Baltimore (Brooklyn)		1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER				10f. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?	
611 Annabel Avenue				21225		USA	
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES?		13. WAS DECEDENT OF HISPANIC ORIGIN?		14. RACE — American Indian, Black, White, etc.	
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		Specify: White	
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		IF YES, GIVE WAR OR DATES		Specify:			
15. DECEDENT'S EDUCATION				16a. DECEDENT'S USUAL OCCUPATION		16b. KIND OF BUSINESS/INDUSTRY	
(Specify only highest grade completed)				(Give kind of work done during most of working life. Do NOT use retired.)			
Elementary/Secondary (0-12)				Homemaker		Housewife	
8th				College (1-4 or 5+)			
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)			
Robert E. L. Freburger				Anna Elizabeth McNamee Freburger			
19a. INFORMANT'S NAME (Type/Print)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
Mrs. Anna E. Bonenberger				611 Annabel Ave., Baltimore, Md. 21225			
20a. METHOD OF DISPOSITION		20b. PLACE OF DISPOSITION		20c. LOCATION — City or Town, State			
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State		(Name of cemetery, crematory or other place)		Baltimore, Maryland			
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		New Cathedral Cemetery					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE		Kevin E. Ecker		22. NAME AND ADDRESS OF FACILITY			
				McCully Funeral Home of Brooklyn 237 E. Patapsco Ave., Balto., Md. 21225			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. <u>uro sepsis</u>							
DUE TO (OR AS A CONSEQUENCE OF):							
b. <u>diabetes mellitus</u>							
DUE TO (OR AS A CONSEQUENCE OF):							
c. _____							
DUE TO (OR AS A CONSEQUENCE OF):							
d. _____							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
<u>s/p CVA</u>							
24a. WAS AN AUTOPSY PERFORMED?		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?					
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEATH (Check only one)					
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH		28a. DATE OF INJURY		28b. TIME OF INJURY		28c. INJURY AT WORK?	
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		(Month, Day, Year)		M		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one)							
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year)	
Pr. Tam S. Scur				D28998			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
9101 Cherry Ln # 211 LAUREL MD 20708							
31. DATE FILED (Month, Day, Year)				32. REGISTRAR'S SIGNATURE			
MAR 07 1991				Julia Davidson-Randall			



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05935

1. DECEDENT'S NAME (First, Middle, Last) <b>Lucy MCKAY</b> Lucy Maud McKay				2. DATE OF DEATH MONTH <b>3</b> DAY <b>2</b> YEAR <b>91</b>		3. TIME OF DEATH <b>5:20 PM</b>			
4. SOCIAL SECURITY NUMBER <b>219-01-4233</b>		5. SEX <b>1</b> <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>98</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>9/3/92</b>		8. BIRTHPLACE (State or Foreign Country) <b>MD.</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>OLD COURT NURSING CENTER</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>RANDALLS TOWN</b>				9c. COUNTY OF DEATH <b>BALTIMORE</b>	
10a. STATE <b>MD</b>				10b. COUNTY <b>Balto.</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>			
10d. INSIDE CITY LIMITS? <b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>1673 NORTHBORNE RD.</b>				10f. ZIP CODE <b>21239</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				11. MARITAL STATUS <b>3</b> <input checked="" type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8th Grade</b> College (1-4 or 5+) <b>-----</b>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>				17. FATHER'S NAME (First, Middle, Last) <b>Alex --- Ridgell</b>	
18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary ---- Bell</b>				19a. INFORMANT'S NAME (Type/Print) <b>Mrs. Susan M. Carlin</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>68 Acorn Circle Apt. # 2 Towson, Md. 21204</b>	
20a. METHOD OF DISPOSITION <b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State <b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Holy Cross Cemetery</b>				20c. LOCATION — City or Town, State <b>A.A.Co.Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>David A. Taylor</b>				22. NAME AND ADDRESS OF FACILITY <b>Balto. Md. 21230 McCully Funeral Home, 130 E. Fort Ave</b>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Arteriosclerotic Cardiovascular disease</b> IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Dementia</b>	
24a. WAS AN AUTOPSY PERFORMED? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO				25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) <b>HOSPITAL:</b> <input checked="" type="checkbox"/> <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA <b>OTHER:</b> <input checked="" type="checkbox"/> Nursing Home <b>8</b> <input type="checkbox"/> Residence <b>9</b> <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH <b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation <b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined <b>3</b> <input type="checkbox"/> Suicide <b>8</b> <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) <b>3/4/91</b>	
28b. TIME OF INJURY <b>M</b>				28c. INJURY AT WORK? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Julia Davidson-Randell</b>				29c. LICENSE NUMBER <b>D18326</b>				29d. DATE SIGNED (Month, Day, Year) <b>3/4/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)								31. DATE FILED (Month, Day, Year) <b>MAR 07 1991</b>	
32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randell</b>								33. DATE OF DEATH (Month, Day, Year) <b>3/4/91</b>	



REG. NO.

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

OHMH-18 Rev 1/89

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

S



ITEM:23pt2 per DOCTOR  
G-673 3/16/91 cm

91 05937

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) BERNARD EDWIN OREM, SR				2. DATE OF DEATH MONTH DAY YEAR 03 04 91		3. TIME OF DEATH 09:15 AM M			
4. SOCIAL SECURITY NUMBER 217-16-3716		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 67 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov. 13, 1923		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) NORTH ARUNDEL HOSPITAL ASSOCIATION				9b. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE			9c. COUNTY OF DEATH A.A. COUNTY		
10a. STATE Maryland		10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Severn			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER 808 Danza Rd.				10f. ZIP CODE 21144		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES W.W. II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12th 4				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Attorney			16b. KIND OF BUSINESS/INDUSTRY Civil Service		
17. FATHER'S NAME (First, Middle, Last) Francis E. Orem				18. MOTHER'S NAME (First, Middle, Maiden Surname) Florence Ebert					
19a. INFORMANT'S NAME (Type/Print) Frances E. Orem				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same As # 10					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) St. Stanislaus Cemetery 3-7			20c. LOCATION — City or Town, State Baltimore, Md.				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Harold B. [Signature]</i>				22. NAME AND ADDRESS OF FACILITY Singleton Funeral Home 1 Second Ave. S.W. Glen Burnie, Md. 21061					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Cardiac Arrest</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Candida Sepsis</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>Chronic cholecystitis</i> DUE TO (OR AS A CONSEQUENCE OF): d. <i>Cerebrovascular accident</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death 0	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Chronic obstructive pulmonary disease</i> <i>congestive heart failure</i> RHEUMATIC HEART DISEASE						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Neil E. Padgett M.D.</i>				29c. LICENSE NUMBER D33296		29d. DATE SIGNED (Month, Day, Year) ▶			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. NEIL E. PADGETT, M.D./7706 QUARTERFIELD ROAD/GLEN BURNIE, MARYLAND 21061									
31. DATE FILED (Month, Day, Year) MAR 7 1991				32. REGISTRAR'S SIGNATURE <i>Julia Davidson</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use in the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JAMES CALVIN PAGE JR.</b>				2. DATE OF DEATH MONTH <b>03</b> DAY <b>02</b> YEAR <b>91</b>		3. TIME OF DEATH <b>4:03 P M</b>	
4. SOCIAL SECURITY NUMBER <b>219-80-8507</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		8. AGE (In yrs. last birthday) <b>31</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>01-04-60</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>UNIVERSITY HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>		9c. COUNTY OF DEATH <b>MD</b>	
10a. STATE <b>MD</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTIMORE, CITY</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>701 NEWINGTON AVE.</b>				10f. ZIP CODE <b>21217</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>TRUCK DRIVER</b>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>JAMES PAGE</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>LILLIE FORD</b>			
19a. INFORMANT'S NAME (Type/Print) <b>ANNETTE B. PAGE</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>701 NEWINGTON AVE./BALTIMORE, MD. 21217</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) <b>BALTIMORE CEMETERY</b>		DATE		20c. LOCATION — City or Town, State <b>BALTIMORE, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Wm. C. March</i>				22. NAME AND ADDRESS OF FACILITY <b>WM.C. MARCH F.H. 1101 E. NORTH AVE.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Gunshot wounds of head</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>03/02/91</b>		28b. TIME OF INJURY <b>3:26p M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED <b>SUBJECT SHOT</b>		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>1000 W. MULBERRY</b>			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Julia Davidson-Rondelle</i>		29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>03/03/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Ann Saxon 111 PENN STREET, BALTIMORE, MARYLAND 21201</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 07 1991</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rondelle</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



FOX BIVERT

91 05939

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ARGENTINA PIPPI</b>				2. DATE OF DEATH MONTH <b>3</b> / DAY <b>5</b> / YEAR <b>91</b>		3. TIME OF DEATH <b>9:45 A M</b>	
4. SOCIAL SECURITY NUMBER <b>220-48-2744</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>.98</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>12-29-92</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Italy</b>				9a. FACILITY NAME (If not institution, give street and number) <b>CHURCHXXX HOSPITAL CORPORATION</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>	
9c. COUNTY OF DEATH <b>-</b>				10a. STATE <b>MD</b>			
10b. COUNTY <b>Baltimore</b>				10c. CITY, TOWN OR LOCATION <b>Essex</b>			
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>300 S. Marlyn Ave.</b>			
10f. ZIP CODE <b>21221</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Eugene Palplizitti</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Oleva Bulletti</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Americo Pippi</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1410 Mt. Carmel Rd. Parkton, Md. 21120</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Sacred Heart of Jesus</b>		20c. LOCATION — City or Town, State <b>Baltimore Co., Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Bruzdziński Funeral Home PA 1407 Eastern Ave. Balto., Md. 21221</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Sepsis / Pneumonia</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <div style="display: flex; align-items: center;"> <div style="font-size: 3em; margin-right: 10px;">{</div> <div> <p>a. <b>Due to (or as a consequence of):</b> <b>Sm. Bowel Obstruction / Polyps</b></p> <p>b. <b>Due to (or as a consequence of):</b> <b>A. Fib. / ASCVD</b></p> <p>c. <b>Due to (or as a consequence of):</b> <b>Renal Insufficiency</b></p> </div> </div>						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D40356</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/5/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>W. NAVARRO 100 N. Broadway, Baltimore MD.</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 07 1991</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH REG. NO.

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

1. DECEDENT'S NAME (First, Middle, Last) <b>VIRGINIA LEE PRITCHETT</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>6</b> YEAR <b>91</b>		3. TIME OF DEATH <b>10:45A</b>									
4. SOCIAL SECURITY NUMBER <b>214-14-8939</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>68</b> YRS.	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>		7. DATE OF BIRTH (Month, Day, Year) <b>11-2-22</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>					
9a. FACILITY NAME (If not institution, give street and number) <b>Sinai Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>				9c. COUNTY OF DEATH <b>N/A</b>							
RESIDENCE OF DECEDENT															
10a. STATE <b>Maryland</b>		10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
10e. STREET AND NUMBER <b>2212 Ken Oak Road</b>				10f. ZIP CODE <b>21209</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5+</b> College (1-4 or 5+) <b>5+</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Vice Principal</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Baltimore City School</b>							
17. FATHER'S NAME (First, Middle, Last) <b>William Howard Snyder</b>						18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Edna Florence Schuehlein</b>									
19a. INFORMANT'S NAME (Type/Print) <b>Morgan H. Pritchett</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2212 Ken Oak Road Baltimore, Maryland 21209</b>											
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Druid Ridge Cemetery</b>				DATE <b>3-9</b>		20c. LOCATION — City or Town, State <b>Pikesville, Maryland</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Dennis Stephen Xenakis</b>				22. NAME AND ADDRESS OF FACILITY <b>Mitchell-Wiedefeld Home 6500 York Road Baltimore, Maryland 21212</b>											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>lung cancer</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. c. d. Approximate Interval Between Onset and Death <b>2 years</b>															
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED							
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)											
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										29b. SIGNATURE AND TITLE OF CERTIFIER <b>[Signature] M.D.</b>		29c. LICENSE NUMBER <b>MD006</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/7/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Eric Rowley M.D. Johns Hopkins Oncology Center Balt, MD 21205</b>															
31. DATE FILED (Month, Day, Year) <b>MAR 07 1991</b>				32. REGISTRAR'S SIGNATURE <b>[Signature]</b>											



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05941

1. DECEDENT'S NAME (First, Middle, Last) HOWARD LEON PECK				2. DATE OF DEATH MONTH DAY YEAR 03 04 91		3. TIME OF DEATH 10:08 A M	
4. SOCIAL SECURITY NUMBER 212-40-1053		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 48 YRS.		7. DATE OF BIRTH (Month, Day, Year) 10/24/1942	
8. FACILITY NAME (If not institution, give street and number) UNION MEMORIAL HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 505 W. UNIVERSITY PARKWAY, APT. F-11				10f. ZIP CODE 21210		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SALESMAN		16b. KIND OF BUSINESS/INDUSTRY STEREO EQUIPMENT			
17. FATHER'S NAME (First, Middle, Last) MILTON PECK				18. MOTHER'S NAME (First, Middle, Maiden Surname) EVE SILBERT			
19a. INFORMANT'S NAME (Type/Print) MR. MILTON PECK				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 505 W. UNIVERSITY PARKWAY, APT. F-11 BALTO., MD 21210			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) HEBREW YOUNG MEN		DATE 3/5/91		20c. LOCATION — City or Town, State BALTIMORE, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ellen Lee Levinson				22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → Atherosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF):  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER A. M. Dixon				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) 03/05/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) A. M. Dixon 111 PENN STREET, BALTIMORE, MARYLAND 21201							
31. DATE FILED (Month, Day, Year) - MAR 7 1991				32. REGISTRAR'S SIGNATURE Julia Davidson-Rodriguez			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1157  
FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05942

1. DECEDENT'S NAME (First, Middle, Last) <b>JOSEPH THOMAS PICKETT</b>		2. DATE OF DEATH MONTH <b>03</b> DAY <b>01</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>5:30 P M</b>	
4. SOCIAL SECURITY NUMBER <b>218-44-7846</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		8. AGE (In yrs. last birthday) <b>42</b> YRS.	
9a. FACILITY NAME (If not institution, give street and number) <b>30 LANDMARK COURT</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>ESSEX</b>		9c. COUNTY OF DEATH <b>BALTIMORE</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Essex</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>30 Landmark Court,</b>		10f. ZIP CODE <b>21221</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>College</b>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Machinist</b>		16b. KIND OF BUSINESS/INDUSTRY <b>A.D.M. Corp.</b>		17. FATHER'S NAME (First, Middle, Last) <b>Ernest B. Pickett</b>	
18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Dorothy M. Lambert Pickett</b>		19a. INFORMANT'S NAME (Type/Print) <b>Mrs. Dorothy E. Pomerantz</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>126 North Janney St., Balto., Md. 21224</b>	
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of temporary crematory or other place) <b>Metro Crematory, Inc. 3/5</b>		20c. LOCATION — City or Town, State <b>Catonsville, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Kevin E. Ecker</b>		22. NAME AND ADDRESS OF FACILITY <b>McCully Funeral Home of Brooklyn 237 E. Patapsco Ave., Balto., Md. 21225</b>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Sudden Inhalation</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   		24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide	
28a. DATE OF INJURY (Month, Day, Year) <b>03 01 1991</b>		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED <b>HOUSEFIRE</b>		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>30 LANDMARK CT.</b>		29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. SIGNATURE AND TITLE OF CERTIFIER <b>[Signature]</b>		29c. LICENSE NUMBER <b>OCME</b>		29d. DATE SIGNED (Month, Day, Year) <b>03 02 1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>A. M. Dixon</b>		31. DATE FILED (Month, Day, Year) <b>MAR 07 1991</b>		32. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

BOILING BOARD

COLLECTION

91 05943

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Byron Ricketts, Sr				2. DATE OF DEATH MONTH 3 DAY 1 YEAR 1991		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER 091-12-8988		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 91 YRS.		7. DATE OF BIRTH (Month, Day, Year) 12-9-1899	
8. BIRTHPLACE (State or Foreign Country) Jamaica		9a. FACILITY NAME (If not institution, give street and number) Granada Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH	
10a. STATE Md				10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 4017 Liberty Heights		10f. ZIP CODE 21207	
10g. CITIZEN OF WHAT COUNTRY? U S A				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: Black			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) Daniels Ricketts				18. MOTHER'S NAME (First, Middle, Maiden Surname) Martha Brown			
19a. INFORMANT'S NAME (Type/Print) Byron Ricketts, Jr				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 67 West Road Wendell, Mass 01379			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory		20c. LOCATION — City or Town, State Catonsville, Md	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Walter Edmond				22. NAME AND ADDRESS OF FACILITY March F/H West 4300 Wabash Avenue			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiac arrhythmia DUE TO (OR AS A CONSEQUENCE OF): b. CVA DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Moses Gebremariam				29c. LICENSE NUMBER D18327		29d. DATE SIGNED (Month, Day, Year) 3/15/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Moses Gebremariam 4660 Wilken Ave #202 21229							
31. DATE FILED (Month, Day, Year) MAR 07 1991				32. REGISTRAR'S SIGNATURE Julia Davidson-Robertson			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MSA

30N COTTON

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>AMY C. ROBINSON</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>1</b> YEAR <b>91</b>				3. TIME OF DEATH <b>M</b>					
4. SOCIAL SECURITY NUMBER <b>220-04-2499</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>24</b> YRS.	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>		7. DATE OF BIRTH (Month, Day, Year) <b>3-31-1966</b>		8. BIRTHPLACE (State or Foreign Country) <b>Md</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Baltimore County General Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Randallstown Baltimore</b>				9c. COUNTY OF DEATH					
RESIDENCE OF DECEDENT													
10a. STATE <b>Md</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER <b>3323 Greenmead Road</b>				10f. ZIP CODE <b>21207</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U S A</b>					
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5 +)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY					
17. FATHER'S NAME (First, Middle, Last) <b>James Robinson</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Joan Edwards</b>									
19a. INFORMANT'S NAME (Type/Print) <b>James Robinson</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3323 Greenmead Road Baltimore, Md 21207</b>									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metro Crematory</b>				20c. LOCATION — City or Town, State <b>Catonsville, Md</b>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Portia Ebron</i>				22. NAME AND ADDRESS OF FACILITY <b>March F/H West 4300 Wabash Avenue</b>									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>SUDDEN DEATH</b> DUE TO (OR AS A CONSEQUENCE OF): a. <b>myocardial infarct - suspected</b> b. <b>Atherosclerosis</b> c. <b>Coronary atherosclerosis</b> d. <b>Coronary atherosclerosis</b> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST										Approximate interval Between Onset and Death <b>min</b> <b>years</b>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes Mellitus I</b> <b>End Stage renal disease</b>										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA		OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		26. PLACE OF DEATH (Check only one)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>3/4/91</b>		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED <b>N/A</b>					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>PAUL D. LIGHT</b> <b>Paul D. Light MD</b>				29c. LICENSE NUMBER <b>D-17522</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/4/91</b>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Upmd Hospital NSW 143 22 S. Green St. Balt. Md. 21201</b>													
31. DATE FILED (Month, Day, Year) <b>MAR 07 1991</b>				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>									



91 05945

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Roland George Repass				2. DATE OF DEATH MONTH DAY YEAR March 2nd 1991		3. TIME OF DEATH 2025 P M	
4. SOCIAL SECURITY NUMBER 218-30-3113		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 59 YRS.		7. DATE OF BIRTH (Month, Day, Year) SEPT. 10, 1931	
9a. FACILITY NAME (If not institution, give street and number) FREDERICK MEMORIAL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH FREDERICK				9c. COUNTY OF DEATH FREDERICK	
RESIDENCE OF DECEDENT							
10a. STATE MD.		10b. COUNTY FREDERICK		10c. CITY, TOWN OR LOCATION FREDERICK		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 2140 WAINWRIGHT COURT 1D				10f. ZIP CODE 21702		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) 0		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) TRUCK DRIVER		16b. KIND OF BUSINESS/INDUSTRY TRUCKING			
17. FATHER'S NAME (First, Middle, Last) STEWART REPASS				18. MOTHER'S NAME (First, Middle, Maiden Surname) HELEN ASBURY			
19a. INFORMANT'S NAME (Type/Print) V. ESTELLE REPASS				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAME AS # 10			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) DARNESTOWN CEMETERY		20c. LOCATION — City or Town, State DARNESTOWN, MD.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Muriel H. Barber		22. NAME AND ADDRESS OF FACILITY MURIEL H. BARBER FUNERAL HOME 21525 LAYTONSVILLE RD. LAYTONSVILLE, MD. 20882					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Lung Cancer (small cell carcinoma) DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death 10 days
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ① Heavy - lifelong cigarette smoking ② Alcoholism							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Charles R. Clark, MD				29c. LICENSE NUMBER D19029		29d. DATE SIGNED (Month, Day, Year) 3/2/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Charles R. Clark, MD 56 Thomas Johnson Dr, Frederick, MD							
31. DATE FILED (Month, Day, Year) MAR 7 1991		32. REGISTRAR'S SIGNATURE Julia Davidson-Randall 22701					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial or cremation permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE										91 05946					
1 - FOR STATE REGISTRAR										REG. NO.					
CERTIFICATE OF DEATH															
1. DECEDENT'S NAME (First, Middle, Last) <i>Snowman Frederick</i>						2. DATE OF DEATH MONTH <i>3</i> DAY <i>5</i> YEAR <i>91</i>		3. TIME OF DEATH <i>8:10 a.m.</i>							
4. SOCIAL SECURITY NUMBER <i>214015245</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>78</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) <i>7-6-12</i>					
9a. FACILITY NAME (If not institution, give street and number) <input checked="" type="checkbox"/> <i>Good Samaritan Hospital</i>						9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i>			9c. COUNTY OF DEATH <i>N/A</i>						
RESIDENCE OF DECEDENT															
10a. STATE <i>Maryland</i>		10b. COUNTY <i>N/A</i>		10c. CITY, TOWN OR LOCATION <i>Baltimore</i>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
10e. STREET AND NUMBER <i>1658 E. Belvedere Ave Apt 202</i>						10f. ZIP CODE <i>21239</i>		10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>							
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>8</i> College (1-4 or 5+) <i></i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Route Salesman</i>				16b. KIND OF BUSINESS/INDUSTRY <i>Koontz Creamery</i>							
17. FATHER'S NAME (First, Middle, Last) <i>Frank Joseph Snowman</i>						18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Elizabeth Josephine Vogel</i>									
19a. INFORMANT'S NAME (Type/Print) <i>A. Jeanette Snowman</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>21239 1658 E. Belvedere Ave Apt 202 Baltimore, Maryland</i>											
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Dulaney Valley Memorial Gardens</i>				20c. LOCATION — City or Town, State <i>Lutherville, Maryland</i>							
21. SIGNATURE OF FUNERAL SERVICE OFFICER <i>Dennis S. Kenakis</i>				22. NAME AND ADDRESS OF FACILITY <i>Mitchell-Wiedefeld Home 6500 York Road Baltimore, Maryland 21212</i>											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Metastatic prostate CA</i>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF):  b. DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d.										Approximate interval between Onset and Death					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										29b. SIGNATURE AND TITLE OF CERTIFIER <i>P. J. Rules, MD</i>		29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year)	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)															
31. DATE FILED (Month, Day, Year) <i>MAR 07 1991</i>				32. REGISTRAR'S SIGNATURE <i>John D. ...</i>											



91 05947

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) John O. Shivers				2. DATE OF DEATH MONTH 3 DAY 1 YEAR 1991		3. TIME OF DEATH 11:00 AM	
4. SOCIAL SECURITY NUMBER 243-20-0192		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 85 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 7-29-1905	
8. BIRTHPLACE (State or Foreign Country) N.C.				9a. FACILITY NAME (If not institution, give street and number) 2 Byers Court		9b. CITY, TOWN OR LOCATION OF DEATH Randallstown	
10a. STATE Md		10b. COUNTY		10c. CITY, TOWN OR LOCATION Randallstown		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 2 Byers Court				10f. ZIP CODE 21133		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6th		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) John N. Shivers				18. MOTHER'S NAME (First, Middle, Maiden Surname) Victoria Johnson			
19a. INFORMANT'S NAME (Type/Print) Amy S. Taylor				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Byers Court Randallstown, Md 21133			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gardens, Homestead Memorial 3-7-91		20c. LOCATION — City or Town, State Greenville, N. C.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Arthur Chron</i>				22. NAME AND ADDRESS OF FACILITY March F/H West 4300 Wabash Avenue			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>ARTEROSCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>PERNICOUS ANEMIA</u> <u>OSTEOARTHRITIS</u>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>MD.</i>				29c. LICENSE NUMBER D19502		29d. DATE SIGNED (Month, Day, Year) 3-5-91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ORLANDO B. CONNOR MD 7501 LIBERTY Rd. BALTO. MD 21207							
31. DATE FILED (Month, Day, Year) MAR 07 1991				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rendell</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 05948

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>DR. HARRY WOLF Schwartz</b>				2. DATE OF DEATH MONTH DAY YEAR <b>MARCH 5, 1991</b>		3. TIME OF DEATH <b>1:30 A M</b>	
4. SOCIAL SECURITY NUMBER <b>117-36-3563</b>		5. SEX <b>1 X M 2 F</b>		6. AGE (In yrs. last birthday) <b>83</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>3/27/1907</b>	
8. BIRTHPLACE (State or Foreign Country) <b>NEW YORK</b>				9a. FACILITY NAME (If not institution, give street and number) <b>6320 GREENSPRING AVE., APT. T-5</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>	
9c. COUNTY OF DEATH				10a. STATE <b>MARYLAND</b>			
10b. COUNTY				10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>			
10d. INSIDE CITY LIMITS? <b>1 X YES 2 NO</b>				10e. STREET AND NUMBER <b>6320 GREENSPRING AVE., APT. T-5</b>			
10f. ZIP CODE <b>21209</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <b>1 X Never Married 2 X Married 3 X Widowed 4 X Divorced</b>		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 X YES 2 NO</b> IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 X YES X NO</b> Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5+</b> College (1-4 or 5+) <b>5+</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>PHYSICIAN</b>		16b. KIND OF BUSINESS/INDUSTRY <b>MEDICINE</b>	
17. FATHER'S NAME (First, Middle, Last) <b>MAX SCHWARTZ</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ANNA FRIEDMAN</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MRS. DORA SCHWARTZ</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6320 GREENSPRING AVE., APT. T-5 BALTO., MD 21209</b>			
20a. METHOD OF DISPOSITION <b>1 X Burial 2 X Cremation 3 X Removal from State 4 X Donation 5 X Other (Specify)</b>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>PROGRESSIVE BENEFIT &amp; SICK RELIEF ASSOC RANDALLSTOWN, MD</b>		20c. LOCATION — City or Town, State <b>3/6/91</b>		20d. LOCATION — City or Town, State <b>BALTIMORE, MD 21215</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Joel D Lewis</b>				22. NAME AND ADDRESS OF FACILITY <b>SOL LEVINSON &amp; BROS., INC. 6010 REISTERSTOWN RD. BALTIMORE, MD 21215</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CARDIOVASCULAR ARREST</b> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>METASTATIC ADENOCARCINOMA</b> Approximate Interval Between Onset and Death <b>4 yr</b> <b>1 yr</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <b>1 X YES 2 X NO</b>		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1 X YES 2 NO</b>					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1 X YES 2 X NO</b>		26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1 X Inpatient 2 ER/Outpatient 3 DOA</b> OTHER: <b>4 X Nursing Home 5 Residence 6 Other (Specify)</b>					
27. MANNER OF DEATH <b>1 X Natural 5 Pending Investigation 2 X Accident 3 Suicide 4 X Homicide 6 Could not be determined</b>		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1 X YES 2 NO</b>	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <b>1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>MD</b>				29c. LICENSE NUMBER <b>D33974</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/5/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Amos D. Galbraith 6804 Park Heights Ave Balto Md 21215</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 7 1991</b>				32. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0680

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the funeral transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 05949

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>PAUL SCHNITZER</b>				2. DATE OF DEATH MONTH <b>3</b> - DAY <b>5</b> - YEAR <b>91</b>		3. TIME OF DEATH <b>740 P.</b>	
4. SOCIAL SECURITY NUMBER <b>217-34-7970</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>89</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>2/22/1902</b>	
8. BIRTHPLACE (State or Foreign Country) <b>POLAND</b>				9a. FACILITY NAME (If not institution, give street and number) <b>3313 SMITH AVE.</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>	
9c. COUNTY OF DEATH <b>BALTIMORE</b>				10a. STATE <b>MARYLAND</b>			
10b. COUNTY <b>BALTIMORE</b>				10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>			
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>3313 SMITH AVE.</b>			
10f. ZIP CODE <b>21208</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>REALTOR</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>REALTOR</b>		16b. KIND OF BUSINESS/INDUSTRY <b>REAL ESTATE</b>			
17. FATHER'S NAME (First, Middle, Last) <b>MAYER SCHNITZER</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>BESSIE (UNKNOWN)</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MARVIN SCHNITZER</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2405 FOREST GREEN RD. BALTIMORE, MD 21209</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>OHEL YAKOV 3/6/91</b>		20c. LOCATION — City or Town, State <b>BALTIMORE, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ellen Levine</i>				22. NAME AND ADDRESS OF FACILITY <b>SOL LEVINSON &amp; BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>ACUTE LEUKEMIA</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <b>PROPHYLAXIS</b> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						Approximate Interval Between Onset and Death	
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Julia Davidson-Randall</i>				29c. LICENSE NUMBER <b>D-20482</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/6/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>1777 REISTERSTOWN RD. BALTIMORE, MD 21208</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 7 1991</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

91 05950

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Robinson Tulie</b>				2. DATE OF DEATH MONTH <b>03</b> DAY <b>05</b> YEAR <b>91</b>		3. TIME OF DEATH <b>3:45a</b>	
4. SOCIAL SECURITY NUMBER <b>212-46-6291</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>46</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>1-24-45</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>University Hosp.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>		9c. COUNTY OF DEATH	
10a. STATE <b>Maryland</b>				10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER <b>1332 N. Calhoun St</b>				10f. ZIP CODE <b>21217</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (14 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Home maker</b>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>Lee Gaither</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Vashtie Wiggins</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mrs. Jean Robinson</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1332 N. Calhoun St Balto. Md. 21217</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other) <b>MT. Zion Cem.</b>		20c. LOCATION — City or Town, State <b>Balto. Co. Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Joseph L. Russ</b>				22. NAME AND ADDRESS OF FACILITY <b>Joseph L. Russ Funeral Home 2202 W. North Ave. Balto. Md. 21216</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Aortic Regurgitation - Severe</b>							
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
b. <b>Endocarditis</b>							
c. <b>Streptococcal bacteremia</b>							
d. <b>Acute Renal Failure</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Acute Renal Failure</b>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27a. DATE OF INJURY (Month, Day, Year)		27b. TIME OF INJURY	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Other (Specify)		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28b. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>Bob Bright MD</b>		29c. LICENSE NUMBER		29d. DATE SIGNED (Month/Day/Year) <b>3/5/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>22 S. Greene Street Baltimore MD</b>							
31. DATE FILED (Month, Day, Year) <b>3/5/MAR 07 1991</b>		32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>					



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05951

1. DECEDENT'S NAME (First, Middle, Last) WASHINGTON I. TAFT				2. DATE OF DEATH MONTH 3 DAY 3 YEAR 1991		3. TIME OF DEATH M					
4. SOCIAL SECURITY NUMBER 218-01-1009		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (in yrs. last birthday) 72 YRS.		7. DATE OF BIRTH (Month, Day, Year) 3-17-1918		8. BIRTHPLACE (State or Foreign Country) N.C.			
9a. FACILITY NAME (If not institution, give street and number) 3059 Ascension Street				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore				9c. COUNTY OF DEATH			
10a. STATE Md				10b. COUNTY				10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 3059 Ascension Street				10f. ZIP CODE 21225				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: Black			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY Longshoreman			
17. FATHER'S NAME (First, Middle, Last) Henry Taft				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lula Washington							
19a. INFORMANT'S NAME (Type/Print) Bernice Taft				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3059 Ascension Street Baltimore, Md 21225							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cedar Hill Cemetery 3-9-91				20c. LOCATION — City or Town, State Anne Arundel Co., Md			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Portia Elron				22. NAME AND ADDRESS OF FACILITY March, E/H West 4300 Wabash Avenue							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CARDIOPULMONARY ARREST DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER Gustave V. Weiss MD				29c. LICENSE NUMBER D38963		29d. DATE SIGNED (Month, Day, Year) 3/6/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Gustave V. Weiss MD 8001 S. HANOVER ST, BALT, MD.											
31. DATE FILED (Month, Day, Year) MAR 07 1991				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall							



91 05952

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Patrick Wayne Walsh, Sr.				2. DATE OF DEATH MONTH DAY YEAR March 5, 1991		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER 219 30 6154		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 55 YRS.		7. DATE OF BIRTH (Month, Day, Year) 11/21/35	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) 2512 Ruscombe Lane		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore	
9c. COUNTY OF DEATH Balto. City				10a. STATE Maryland		10b. COUNTY Balto. City	
10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 2512 Ruscombe Lane	
10f. ZIP CODE 21215				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1956-1962				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Asst. Director Physical Operations		16b. KIND OF BUSINESS/INDUSTRY Towson State University	
17. FATHER'S NAME (First, Middle, Last) Edward T. Walsh				18. MOTHER'S NAME (First, Middle, Maiden Surname) Viola M. Phillips			
19a. INFORMANT'S NAME (Type/Print) Patricia A. Walsh				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2512 Ruscombe Lane, Baltimore, Maryland 21215			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify):				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Maryland Veterans cemetery		20c. LOCATION — City or Town, State Garrison Forest, Md	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Lucy Henss Carpenter</i>				22. NAME AND ADDRESS OF FACILITY Burgee-Henss Funeral Home 3631 Falls Road, Baltimore, Maryland 21211			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → METASTATIC HEIDONMYOSARCOMA - DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate interval Between Onset and Death Months
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CVA with hemiparesis							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Kenneth M. Zinsmeister MD</i>				29c. LICENSE NUMBER D-20333		29d. DATE SIGNED (Month, Day, Year) 3/5/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) K. Zinsmeister MD, 1777 Reisterstown Rd, Pikesville, Md							
31. DATE FILED (Month, Day, Year) MAR 07 1991				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



ITEMS: 23, 27, 28d Unknown 91-29  
per ME G-675 5/16/91 cm  
91-980-510

1 FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05953

1. DECEDENT'S NAME (First, Middle, Last) <b>ANTHONY MARIO WOFFORD</b>		2. DATE OF DEATH MONTH DAY YEAR <b>02 20 1991</b>		3. TIME OF DEATH <b>4:01 P M</b>	
4. SOCIAL SECURITY NUMBER <b>218-80-2279</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>30</b> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <b>2 11 61</b>		8. BIRTHPLACE (State or Foreign Country) <b>Md</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Shock Trauma Center</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>		9c. COUNTY OF DEATH	
10a. STATE <b>Maryland</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>2614 Cylburn Avenue</b>		10f. ZIP CODE	
10g. CITIZEN OF WHAT COUNTRY?		11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY <b>Wofford Garage</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Marion Wofford</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Greene</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Marion Wofford</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4928 Lanier Avenue Baltimore, Md 21215</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Western Star Cemetery</b>		20c. LOCATION — City or Town, State <b>Catonsville, Md</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY <b>March F/H West 4300 Wabash Avenue</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>GUNSHOT WOUND OF HEAD</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF):  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>02 20 1991</b>		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED <b>SUBJECT SHOT HIMSELF Gunshot wound to head (right side)</b>		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>3101 Swann Drive, Balto, City</b>	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER <b>O.C.M.E.</b>	
29d. DATE SIGNED (Month, Day, Year) <b>02 21 1991</b>		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MARIO F. GOLLE JR. MD 111 Penn Street, Baltimore, Maryland 21201</b>			
31. DATE FILED (Month, Day, Year) <b>MAR 07 1991</b>		32. REGISTRAR'S SIGNATURE 			

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION







91-980-510

91 05953

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ANTHONY MARIO WOFFORD</b>				2. DATE OF DEATH MONTH <b>02</b> DAY <b>20</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>4:01 P M</b>	
4. SOCIAL SECURITY NUMBER <b>218-80-2279</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AOE (In yrs. last birthday) <b>30</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>2 11 61</b>	
8. FACILITY NAME (If not institution, give street and number) <b>Shock Trauma Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>		9c. COUNTY OF DEATH <b>Md</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>2614 Cylburn Avenue</b>			
10f. ZIP CODE <b>21215</b>				10g. CITIZEN OF WHAT COUNTRY?			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY <b>Wofford Garage</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Marion Wofford</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Greene</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Marion Wofford</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4928 Lanier Avenue Baltimore, Md 21215</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Western Star Cemetery</b>		20c. LOCATION — City or Town, State <b>Catonsville, Md</b>		20d. DATE <b>22891</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Portia Ebron</i>				22. NAME AND ADDRESS OF FACILITY <b>March F/H West 4300 Wabash Avenue</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>pending</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Hurling Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <b>02 20 1991</b>		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED <b>Gunshot Wound to head (bullet wound)</b>		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>Druid Hill Park</b>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>3101 Swann Drive, Balto, City</b>			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John F. Galle, M.D.</i>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>02 21 1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MARIO F. GALLE JR. MD 111 Penn Street, Baltimore, Maryland 21201</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 07 1991</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH91 05954  
REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ROZELLA WITHERSPOON</b>		2. DATE OF DEATH MONTH <b>03</b> DAY <b>02</b> YEAR <b>91</b>		3. TIME OF DEATH <b>235</b> A M	
4. SOCIAL SECURITY NUMBER <b>215-24-8286</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>66</b> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <b>12-24-24</b>		8. BIRTHPLACE (State or Foreign Country) <b>S.C.</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Liberty Medical Center</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Balto</b>		9c. COUNTY OF DEATH	
10a. STATE <b>MD</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Balto</b>	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>2712 W. Mosher St</b>		10f. ZIP CODE <b>21216</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9th</b> College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <b>Henry McFadden</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Rosa Skeeta</b>			
19a. INFORMANT'S NAME (Type/Print) <b>John Witherspoon</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2712 W. Mosher St Balto, MD 21216</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Garrison Forest Vot 3791</b>		20c. LOCATION — City or Town, State <b>Owings Mills, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Portia Ebron</b>		22. NAME AND ADDRESS OF FACILITY <b>March F. H. West 4300 Wabash Ave</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Recurrent cerebral infarction</b>  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { <b>end stage renal disease</b> <b>NI BDM</b> <b>HTN</b>		Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>Charles Zaurthorn</b>		29c. LICENSE NUMBER <b>D40193</b>	
29d. DATE SIGNED (Month, Day, Year) <b>03-02-91</b>		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)			
31. DATE FILED (Month, Day, Year) <b>MAR 07 1991</b>		32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) <b>Christopher J. Wiesner II</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>2</b> YEAR <b>91</b>		3. TIME OF DEATH <b>6:45 P M</b>	
4. SOCIAL SECURITY NUMBER <b>233-29-5170</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>4</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>1-4-86</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Potomac River</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Hagerstown</b>		9c. COUNTY OF DEATH <b>Washington</b>	
10a. STATE <b>W. Virginia</b>		10b. COUNTY <b>Berkeley</b>		10c. CITY, TOWN OR LOCATION <b>Hedgesville</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>Rt. 3 Box 160-14</b>				10f. ZIP CODE <b>25427</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (8-12)</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Child</b>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>Christopher J. Wiesner</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Laurie Jeanne Morton</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Dolores M. Wiesner</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>22 Sipple Avenue Baltimore, Maryland-21206</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Parkwood Cem. 3-6-91</b>		20c. LOCATION — City or Town, State <b>Baltimore, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Kathleen M. Murphy</i>				22. NAME AND ADDRESS OF FACILITY <b>6415 Belair Road John C. Miller, Inc. Baltimore, Md.-21206</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Pneumonia</b> a. DUE TO (OR AS A CONSEQUENCE OF):  Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>3-2-91 found</b>		28b. TIME OF INJURY <b>4:30 PM</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>Potomac River</b>		28d. DESCRIBE HOW INJURY OCCURRED <b>Passenger auto swept off bridge</b>				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>Potomac River</b>	
29. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John F. Galt, Jr. M.D.</i>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>3-4-91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MARK F. GALT, JR. M.D. 111 Penn St. Baltimore, Md.</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 7 1991</b>		32. REGISTRAR'S SIGNATURE <i>John F. Galt, Jr.</i>					

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				91 05956	
1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH				3. TIME OF DEATH	
THELMA REBECCA WALDROP				MONTH DAY YEAR 3-07-91				17:19 M	
4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (in yrs. last birthday)	7. DATE OF BIRTH		8. BIRTHPLACE (State or Foreign Country)			
212-36-2856		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	79 YRS.	April 10, 1911		Maryland			
9a. FACILITY NAME (If not institution, give street and number)				9b. CITY, TOWN OR LOCATION OF DEATH				9c. COUNTY OF DEATH	
Francis Scott Key Medical Center				Baltimore City					
RESIDENCE OF DECEDENT									
10a. STATE		10b. COUNTY		10c. CITY, TOWN OR LOCATION		10d. INSIDE CITY LIMITS?			
Maryland		Baltimore		Edgemere		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER				10f. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?			
5 Strebor Road				21219		United States			
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES?		13. WAS DECEDENT OF HISPANIC ORIGIN?		14. RACE — American Indian, Black, White, etc.			
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY			
Elementary/Secondary (0-12) 11 years College (14 or 5+) n/a				Homemaker		own home			
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)					
William Edward Watts				Julia Belle Stump					
19a. INFORMANT'S NAME (Type/Print)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)					
Julia A. Roberts				5 Strebor Road Baltimore, Maryland 21219					
20a. METHOD OF DISPOSITION		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		DATE		20c. LOCATION — City or Town, State			
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		Meadowridge Memorial Park 3/7/91		Dorsey, Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE				22. NAME AND ADDRESS OF FACILITY					
Brian T. Chisholm				Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue, Balto., MD 21222					
23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory Arrest DUE TO (OR AS A CONSEQUENCE OF):									
b. Pneumonia DUE TO (OR AS A CONSEQUENCE OF):									
c. Chronic Obstructive Pulmonary Disease DUE TO (OR AS A CONSEQUENCE OF):									
d.									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
Stroke Atrial Fibrillation Diabetes								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one)					
				HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one)				29b. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year)			
Bruce A. Cabin Resident						03-07-91			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)									
Francis Scott Key Hospital Baltimore Maryland									
31. DATE FILED (Month, Day, Year)				32. REGISTRAR'S SIGNATURE					
3-07-91 MAR 07 1991				Julia Davidson-Randall					





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				91-05957	
1 - FOR STATE REGISTRAR				REG. NO. 91 05957	
CERTIFICATE OF DEATH					
1. DECEDENT'S NAME (First, Middle, Last) <b>RUSSELL I. YEALD HALL</b>		2. DATE OF DEATH MONTH <b>3</b> DAY <b>6</b> YEAR <b>91</b>		3. TIME OF DEATH <b>0430</b> M	
4. SOCIAL SECURITY NUMBER <b>212-01-6842</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>77</b> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <b>04-28-1913</b>		8. BIRTHPLACE (State or Foreign Country) <b>Md.</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>St. Agnes Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>		9c. COUNTY OF DEATH <b>N/A</b>	
RESIDENCE OF DECEDENT					
10a. STATE <b>Md.</b>		10b. COUNTY <b>Anne Arundel</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER <b>115 West Hilltop Road</b>		10f. ZIP CODE <b>21225</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th Grade</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Sign Painter</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Bell Singer Sign</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Henry Irving Yeald Hall</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Francis Willard Bauer</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mr. Charles Yeald Hall</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10361 New Quay Road; Ocean City, Md. 21842</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Loudon Park Cemetery</b>		20c. LOCATION — City or Town, State <b>Baltimore, Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>James F. Hackman Jr.</b>		22. NAME AND ADDRESS OF FACILITY <b>McCully Funeral Home 237 E. Patapsco Avenue; Balto., Md. 21225</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Septic Shock.</b> IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. DUE TO (OR AS A CONSEQUENCE OF): <b>Unoperated</b> b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. SEQUENTIALLY list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST					Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
					24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <b>AS 2438524-753</b>		29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>3/6/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>CLERA A SAMUELS ST Agnes Hospital Caton Ave</b>					
31. DATE FILED (Month, Day, Year) <b>MAR 07 1991</b>		32. REGISTRAR'S SIGNATURE <b>Jelia Davidson-Randall</b>			



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 91-05958

1. DECEDENT'S NAME (First, Middle, Last) <b>ALBERT GEORGE AIST</b>		2. DATE OF DEATH MONTH <b>2</b> - DAY <b>9</b> - YEAR <b>1991</b>		3. TIME OF DEATH <b>11:53 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>215-36-3292</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		8. AGE (In yrs. last birthday) <b>90</b> YRS.	
9a. FACILITY NAME (If not institution, give street and number) <b>Washington Adventist Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Takoma Park</b>		9c. COUNTY OF DEATH <b>Montgomery</b>	
RESIDENCE OF DECEDENT					
10a. STATE <b>Md.</b>		10b. COUNTY <b>P.G.</b>		10c. CITY, TOWN OR LOCATION <b>Upper Marlboro</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER <b>11601 Van Brady Road</b>		10f. ZIP CODE <b>20772</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (14 or 5+) <b>0</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Tax Acsser</b>		16b. KIND OF BUSINESS/INDUSTRY <b>P.G. County</b>	
17. FATHER'S NAME (First, Middle, Last) <b>George A. Aist</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Sarah J. Stewart</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Clark Aist</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11701 Van Brady Rd., Upper Marlboro, Md. 20772</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Trinity Mem. Gardens Cem.</b>		20c. LOCATION — City or Town, State <b>Waldorf, Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>		22. NAME AND ADDRESS OF FACILITY <b>Lee Funeral Home, Inc.</b> <b>6633 Old Alexander Ferry Road</b> <b>Clinton, Md. 20735</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CARDIO RESPIRATORY ARREST</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>SENILITY</b> DUE TO (OR AS A CONSEQUENCE OF): <b>ARRHYTHMIA</b> DUE TO (OR AS A CONSEQUENCE OF): <b>HYPOTHYROIDISM.</b>					Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
					24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Tony P. Kannarkat MD</b>		29c. LICENSE NUMBER <b>D-20062</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/9/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>TONY P. KANNARKAT. MD. 8201 16th ST. SILVER SPRING, MD 20910</b>					
31. DATE FILED (Month, Day, Year) <b>FEB 21 '91</b>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be attached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

4

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05959

1. DECEDENT'S NAME (First, Middle, Last) <b>JAMES H. AYDELOTTE</b>		2. DATE OF DEATH MONTH <b>2</b> DAY <b>11</b> YEAR <b>91</b>		3. TIME OF DEATH <b>1:00 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>220-07-5941</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>82</b> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <b>2-27-08</b>		8. BIRTHPLACE (State or Foreign Country) <b>V.A.</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>HOME 214 EAST MARTIN</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>SNOW HILL</b>		9c. COUNTY OF DEATH <b>WORCESTER</b>	
10a. STATE <b>M.D.</b>		10b. COUNTY <b>WORCESTER</b>		10c. CITY, TOWN OR LOCATION <b>SNOW HILL</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>214 EAST MARTIN</b>		10f. ZIP CODE <b>21863</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLK</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>RETIRED</b>		16b. KIND OF BUSINESS/INDUSTRY <b>SCOTTS PAPER</b>		17. FATHER'S NAME (First, Middle, Last) <b>JAMES ADELOTTE</b>	
18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>LAURA AYDELOTTE</b>		19a. INFORMANT'S NAME (Type/Print) <b>MAMIE A. AYDELOTTE</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>214 EAST MARTIN ST. SNOW HILL MD. 21863</b>	
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>EBYNEQIA CEMETERY</b>		20c. LOCATION — City or Town, State <b>SNOW HILL</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>RUSSELL FOOKS</b> <i>Russell Fooks</i>		22. NAME AND ADDRESS OF FACILITY <b>FOOKS FTH POB 1574 SALISBURY MD. 21801</b>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Arteriosclerotic Heart Disease</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypertension</b>		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>Peter S. Abbott MD Medical Examiner</b>		29c. LICENSE NUMBER <b>D30619</b>	
29d. DATE SIGNED (Month, Day, Year) <b>2/22/91</b>		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>PETER S. ABBOTT MD 10445 OCEANO CITY BLVD BERLIN, MD 21811</b>		31. DATE FILED (Month, Day, Year) <b>FEB 25 '91</b>	
32. REGISTRAR'S SIGNATURE <i>Gula Davidson-Randall</i>					

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MATHEW J. AYDELOTTE, SR</b>			2. DATE OF DEATH MONTH DAY YEAR <b>FEB. 14, 1991</b>		3. TIME OF DEATH M <b>1430</b>
4. SOCIAL SECURITY NUMBER <b>717-10-6442</b>	5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (in yrs. last birthday) <b>74</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>10-3-1916</b>	8. BIRTHPLACE (State or Foreign Country) <b>Md.</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>PENINSULA GENERAL HOSPITAL</b>			9b. CITY, TOWN OR LOCATION OF DEATH <b>SALISBURY</b>		9c. COUNTY OF DEATH <b>WICOMICO</b>
10a. STATE <b>De.</b>			10b. COUNTY <b>Sussex</b>		10c. CITY, TOWN OR LOCATION <b>Delmar</b>
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			10e. STREET AND NUMBER <b>901 E. State St.</b>		
10f. ZIP CODE <b>19940</b>			10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Engineering Consultant</b>		16b. KIND OF BUSINESS/INDUSTRY <b>P &amp; A Construction Co.</b>			
17. FATHER'S NAME (First, Middle, Last) <b>William H. Aydelotte III</b>			18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Anna Matthews Aydelotte</b>		
19a. INFORMANT'S NAME (Type/Print) <b>Catherine H. Aydelotte</b>			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>901 E. State St. Delmar, De. 19940</b>		
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>St. Stephens Cemetery</b>		20c. LOCATION — City or Town, State <b>Delmar, De.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>William M. Short</i>			22. NAME AND ADDRESS OF FACILITY <b>Short Funeral Home, Inc. P.O. Box 204 Delmar, De. 19940</b>		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acute Pneumonia</b> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>Chronic Lymphocytic Leukemia</b> PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Seizure Disorder</b>					Approximate Interval Between Onset and Death
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Eddie Velazquez</i>			29c. LICENSE NUMBER <b>040190</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/14/91</b>
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Eddie Velazquez, MD Salisbury Medcenter, Salisbury, MD</b>					
31. DATE FILED (Month, Day, Year) <b>FEB 20 1991</b>		32. REGISTRAR'S SIGNATURE <i>L. H. Fisher</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH REG. NO.

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>CLAYTON EDWARD ALVEY, SR.</b>				2. DATE OF DEATH MONTH <b>FEB.</b> DAY <b>20,</b> YEAR <b>1991</b>				3. TIME OF DEATH <b>6:15 A.M.</b>									
4. SOCIAL SECURITY NUMBER <b>577-07-8227</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>87</b> YRS.		IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>		7. DATE OF BIRTH (Month, Day, Year) <b>NOV. 12, 1903</b>		8. BIRTHPLACE (State or Foreign Country) <b>WASHINGTON, D.C.</b>					
9a. FACILITY NAME (If not institution, give street and number) <b>AT HOME, ROUTE 5 SOUTH</b>						9b. CITY, TOWN OR LOCATION OF DEATH <b>GREAT MILLS</b>				9c. COUNTY OF DEATH <b>ST. MARY'S COUNTY</b>							
10a. STATE <b>MD.</b>												10b. COUNTY <b>ST. MARY'S CO.</b>		10c. CITY, TOWN OR LOCATION <b>GREAT MILLS</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>ROUTE 5 SOUTH, GENERAL DELIVERY</b>						10f. ZIP CODE <b>20634</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12TH GRADE</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>MANAGER</b>				16b. KIND OF BUSINESS/INDUSTRY <b>WAREHOUSE</b>									
17. FATHER'S NAME (First, Middle, Last) <b>GEORGE E. ALVEY</b>						18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>CLARA SARAH HAYES</b>											
19a. INFORMANT'S NAME (Type/Print) <b>EDNA LEONA ALVEY</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>ROUTE 5 SOUTH, GREAT MILLS, MARYLAND 20634</b>													
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>HOLY FACE CATHOLIC CEMETERY</b>				20c. LOCATION — City or Town, State <b>GREAT MILLS, MARYLAND</b>									
21. SIGNATURE OF FUNERAL SERVICE LICENSER <i>Michael R. Gardiner</i>						22. NAME AND ADDRESS OF FACILITY <b>MATTINGLEY-GARDINER FUNERAL HOME, P.A. P.O. BOX 270, LEONARDTOWN, MD. 20650</b>											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>a. CARDIO Respiratory failure</b> <b>b. Sick sinus node disease</b> <b>c. Peripheral vascular disease</b> <b>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> <b>d.</b>												Approximate Interval Between Onset and Death					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)													
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED							
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)											
29a. CERTIFIER <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																	
29b. SIGNATURE AND TITLE OF CERTIFIER <i>B. Jhaвери</i>						29c. LICENSE NUMBER <b>D 33470</b>			29d. DATE SIGNED (Month, Day, Year) <b>2/21/91</b>								
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>B. JHAVERI, MD. SHANTI MEDICAL CENTER, LEONARDTOWN, MARYLAND 20650</b>																	
31. DATE FILED (Month, Day, Year) <b>FEB 22 91</b>				32. REGISTRAR'S SIGNATURE <i>John W. Anderson</i>													

**TO BE COMPLETED BY FUNERAL DIRECTOR**

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

(12)



91 05962

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <b>LOUISE EVELYN BOSS</b>				2. DATE OF DEATH MONTH <b>02</b> DAY <b>15</b> YEAR <b>91</b>		3. TIME OF DEATH <b>3:00 am</b> M	
4. SOCIAL SECURITY NUMBER <b>578-03-7062</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>79</b> YRS.		7. DATE OF BIRTH MONTH <b>01</b> DAY <b>21</b> YEAR <b>1912</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>524 Forest Hills Drive</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Annapolis</b>		9c. COUNTY OF DEATH <b>Anne Arundel</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Prince George's</b>		10c. CITY, TOWN OR LOCATION <b>Hyattsville</b>	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>4308 Underwood Street</b>			
10f. ZIP CODE <b>20782</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th Grade</b> College (1-4 or 5+) <b>4 Years</b>				16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Registered Nurse</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Federal Government</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Arthur Elmore Martin</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mattie May Lee</b>			
19a. INFORMANT'S NAME (Type in full) <b>Kenneth T. Boss [son]</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>524 Forest Hills Drive, Annapolis, Md. 21403</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Fort Lincoln Cemetery</b>		20c. LOCATION — City or Town, State <b>Brentwood, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, Md. 20781</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Pulmonary Edema</b> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): <b>Coronary Heart Failure</b> b. DUE TO (OR AS A CONSEQUENCE OF): <b>Ischemic Heart Disease</b> c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>D36488</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/15/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>William Behrens 2568 Riva Road, Suite #202, Annapolis, Maryland 21401</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 19 '91</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 05963

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Justina May Bolsinger		2. DATE OF DEATH MONTH DAY YEAR 2.18.91		3. TIME OF DEATH 10:15 AM	
4. SOCIAL SECURITY NUMBER 168-09-6670		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (in yrs. last birthday) 90 YRS.	
9a. FACILITY NAME (If not institution, give street and number) PRINCE GEORGE'S HOSPITAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH CHEVERLY		9c. COUNTY OF DEATH PRINCE GEORGE'S	
RESIDENCE OF DECEDENT					
10a. STATE Maryland		10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION Bladensburg	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO					
10e. STREET AND NUMBER 4201 Edmonston Avenue		10f. ZIP CODE 20710		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home	
17. FATHER'S NAME (First, Middle, Last) Howard Rager		18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna L. (Unavailable)			
19a. INFORMANT'S NAME (Type/Print) Paul Ridenour (Grandson)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 158 G Street, S.W., Washington, D.C. 20024			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Fort Lincoln Cemetery		20c. LOCATION — City or Town, State Brentwood, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Paul H. Brooker</i>		22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave. Hyattsville, Md. 20781			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cerebral Thrombosis</i>					
Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <i>Coronary Artery Disease</i>					
{ <i>B. Hypertension</i>					
{ <i>Peripheral Vascular Disease</i>					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Chronic Urinary Tract Infection</i>					
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — A1 home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>J. L. Loeblin</i>		29c. LICENSE NUMBER D10346 Mo		29d. DATE SIGNED (Month, Day, Year) 2.18.91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Ohannes Sahakian, M.D. 5632 Annapolis Road, Bladensburg, Maryland 20710					
31. DATE FILED (Month, Day, Year) FEB 22 '91		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Page 1 of 1

1. The first part of the document discusses the importance of maintaining accurate records of all transactions. It emphasizes that proper record-keeping is essential for the integrity of the financial system and for the ability to detect and prevent fraud.

2. The second part of the document outlines the specific procedures for recording transactions. It details the steps involved in the accounting process, from the initial entry of a transaction into the ledger to the final posting to the general ledger.

3. The third part of the document discusses the role of the auditor in verifying the accuracy of the records. It describes the various techniques used by auditors to test the reliability of the accounting system and to ensure that the financial statements are true and fair.

4. The fourth part of the document discusses the importance of internal controls in preventing errors and fraud. It describes the various types of controls that can be implemented, such as segregation of duties, authorization requirements, and physical controls.

5. The fifth part of the document discusses the importance of the accounting system in providing information to management. It describes the various types of reports that can be generated from the accounting system and how they can be used to make informed business decisions.

91 05964

91-1007-033

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Carey WAYNE Brodsky				2. DATE OF DEATH MONTH 2 DAY 21 YEAR 1991		3. TIME OF DEATH 1:35 a m	
4. SOCIAL SECURITY NUMBER 216-60-3545		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		8. AGE (In yrs. last birthday) 37 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug. 11, 1953	
9a. FACILITY NAME (If not institution, give street and number) Prince Georges Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Cheverly		9c. COUNTY OF DEATH Prince Georges			
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION Bladensburg		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 4107 51st Street Apt. #103				10f. ZIP CODE 20710		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) -----		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Machinist		16b. KIND OF BUSINESS/INDUSTRY Printing Company			
17. FATHER'S NAME (First, Middle, Last) William Brodsky				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lillian C. Ceiba			
19a. INFORMANT'S NAME (Type/Print) Lillian Brodsky				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4107 51st Street, Apt. 103, Bladensburg, Md. 20710			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) Ft. Lincoln Cemetery 02-25-91		20c. LOCATION — City or Town, State Brentwood, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Paul H. Brodsky</i>		22. NAME AND ADDRESS OF FACILITY FRANCIS GASCH'S SONS FUNERAL HOME 4739 Balt. Ave., Hyattsville, Md. 20781					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Narcotic Intoxication</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
26. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input checked="" type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		27a. DATE OF INJURY (Month, Day, Year)		27b. TIME OF INJURY M		27c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
27d. DESCRIBE HOW INJURY OCCURRED		27e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		27f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Mario F. Golie, Jr. MD</i>				29c. LICENSE NUMBER OCME		29d. DATE SIGNED (Month, Day, Year) 2/21/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) MARIO F. GOLIE, JR. MD 111 PENN ST. BALTO MD 21201							
31. DATE FILED (Month, Day, Year) FEB 22 '91				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Mary P. Brown				2. DATE OF DEATH MONTH DAY YEAR February 24 1991		3. TIME OF DEATH 0240 A.M.	
4. SOCIAL SECURITY NUMBER 215-44-5902		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 88 YRS.		7. DATE OF BIRTH (Month, Day, Year) 3/28/02	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) PENINSULA GENERAL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY	
9c. COUNTY OF DEATH WICOMICO				10a. STATE Maryland		10b. COUNTY Wicomico	
10c. CITY, TOWN OR LOCATION Salisbury				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 300 Lemmon Hill	
10f. ZIP CODE 21801				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home	
17. FATHER'S NAME (First, Middle, Last) Charles H. Parsons				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mollie Corddry			
19a. INFORMANT'S NAME (Type/Print) Anne G. Hastings				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9726 Buckingham Lane, Berlin, Maryland 21811			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Whatcoat Methodist		20c. LOCATION — City or Town, State Snow Hill, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Dennis Fleury</i>				22. NAME AND ADDRESS OF FACILITY Dennis Funeral Home 110 Franklin St., Snow Hill, Md. 21863			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Respiratory Failure</i> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Congestive Heart Failure</i>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Paul R. Fleury MD</i>				29c. LICENSE NUMBER D 24872		29d. DATE SIGNED (Month, Day, Year) 2/24/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) PAUL R. FLEURY MD, 560 RIVERSIDE DRIVE SUITE 204 A SALISBURY MD.							
31. DATE FILED (Month, Day, Year) FEB 25 '91				32. REGISTRAR'S SIGNATURE <i>John W. Anderson</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Louise H. Brooke</b>				2. DATE OF DEATH MONTH DAY YEAR <b>Feb 15 91</b>		3. TIME OF DEATH <b>2:15 PM</b>	
4. SOCIAL SECURITY NUMBER <b>578-38-0933</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>76</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>June 6, 1914</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Pennsylvania</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Charles County Nursing Home</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>LaPlata</b>	
9c. COUNTY OF DEATH <b>Charles</b>				10a. STATE <b>Maryland</b>			
10b. COUNTY <b>Prince George's</b>				10c. CITY, TOWN OR LOCATION <b>Temple Hills</b>			
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>5084 Temple Hill Rd.</b>			
10f. ZIP CODE <b>20748</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Accountant— Self Emp.</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Accounting</b>			
17. FATHER'S NAME (First, Middle, Last) <b>George Joseph Helfrich</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Agnes C. Collins</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Louise Kloiber</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10902 New England Dr., Clinton, Md. 20735</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>St. Ignatius Church Cemetery</b>		20c. LOCATION — City or Town, State <b>Oxon Hill, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George P. Kalas</i>				22. NAME AND ADDRESS OF FACILITY <b>George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, Maryland</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>pneumonia</b> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>sepsis</b> <b>atelectasis left lung</b>						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Alzheimer's Disease, Multiple infarct dementia, Coronary Artery Disease, Hypertension, Left heart failure.</b>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Paul E. Pritchett MD</i>				29c. LICENSE NUMBER <b>1208370</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/15/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Paul E. Pritchett, M.D. 118 La Grange Ave. La Plata, Maryland 20646</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 21 '91</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) WILLIAM BUTLER				2. DATE OF DEATH MONTH DAY YEAR FEB 15 1991		3. TIME OF DEATH 4:55p M		
4. SOCIAL SECURITY NUMBER 251-22-5725-A		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 67 YRS.		7. DATE OF BIRTH (Month, Day, Year) 10 23 23		
8a. FACILITY NAME (If not institution, give street and number) Malcolm Grow Hospital AAFB				8b. CITY, TOWN OR LOCATION OF DEATH Camp Springs		8c. COUNTY OF DEATH Prince George's		
10a. STATE Maryland				10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION Largo		
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO								
10e. STREET AND NUMBER 10110 Campus Way South #203				10f. ZIP CODE 20772		10g. CITIZEN OF WHAT COUNTRY? U.S.A.		
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2nd College (1-4 or 5+) N/A		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Laborer		16b. KIND OF BUSINESS/INDUSTRY Cotton Mill				
17. FATHER'S NAME (First, Middle, Last) Charlie Butler				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lucille Bailey				
19a. INFORMANT'S NAME (Type/Print) Bessie Norris				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as 10 A-F				
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Calvary Cemetery		20c. LOCATION — City or Town, State Hodges South Carolina				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY Lee Funeral Home, Inc. 6633 Old Alexander Ferry Rd Clinton, Md 20735				
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → SQUAMOUS CELL CANCER OF LUNG DUE TO (OR AS A CONSEQUENCE OF):								
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF):								
DUE TO (OR AS A CONSEQUENCE OF):								
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
		28d. DESCRIBE HOW INJURY OCCURED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
		28f. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD				29c. LICENSE NUMBER --		29d. DATE SIGNED (Month, Day, Year) 2-15-91		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ROBERT B GOOD, CAPT, USAF, MC MALCOLM GROW USAF MED CENTER ANDREWS AFB MD 20331-5300								
31. DATE FILED (Month, Day, Year) FEB 21 '91		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>						

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>LELAND E. BARRETT</b> Leland Ellison Barrett Jr				2. DATE OF DEATH MONTH DAY YEAR <b>2 16 91</b>		3. TIME OF DEATH <b>5:10PM</b>	
4. SOCIAL SECURITY NUMBER <b>577-18-0093</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>72</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>01 26 19</b>	
8. FACILITY NAME (If not institution, give street and number) <b>Southern Maryland Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Clinton</b>		9c. COUNTY OF DEATH <b>Prince Georges Co.</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Prince George's</b>		10c. CITY, TOWN OR LOCATION <b>Clinton</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>8100 Poplar Hill Drive</b>				10f. ZIP CODE <b>20735</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WWII</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Caucasian</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11th</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Grocery Clerk</b>		15b. KIND OF BUSINESS/INDUSTRY <b>A &amp; P Food</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Leland E. Barrett Sr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Marguerite E. Bonck</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Jerry Barrett</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Same as 10 A-F</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name (Specify cemetery, crematory or other place) <b>Parklawn Cemetery</b>		DATE <b>2 21 91</b>		20c. LOCATION — City or Town, State <b>Rockville, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Lee Funeral Home, Inc.</b> <b>6633 Old Alexander Ferry Rd Clinton, Md 20735</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiopulmonary Arrest</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <b>Gram negative Septicaemia</b> b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Dementia, Cerebrovascular Disease</b> <b>Emphysema, Coronary Heart Disease</b>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>G.S. RATH (Attending Physician)</b>				29c. LICENSE NUMBER <b>D12587</b>		29d. DATE SIGNED (Month, Day, Year) <b>2-18-91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>G.S. RATH, 7C POST OFFICE RD, WALDORF MD. 20602</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 21 '91</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020  
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





91 05969

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>CHARLOTTE SNOWDEN BAILLIE</b>				2. DATE OF DEATH MONTH <b>00</b> DAY <b>11</b> YEAR <b>91</b>		3. TIME OF DEATH <b>1:10</b> A M	
4. SOCIAL SECURITY NUMBER <b>217-52-5423</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>94</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>08-10-1896</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>							
9a. FACILITY NAME (If not institution, give street and number) <b>Greater Laurel-Beltsville Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Laurel</b>		9c. COUNTY OF DEATH <b>Prince George's</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Prince George's</b>		10c. CITY, TOWN OR LOCATION <b>Mount Rainier</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>4019 37th Street</b>				10f. ZIP CODE <b>20712</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7th Grade</b> College (1-4 or 5+) <b>Payroll Clerk</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Gov't. Printing Office</b>		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <b>Frederick B. Snowden</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Adalaide Smith</b>			
19a. INFORMANT'S NAME (Type/Print) <b>James W. Freeman</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3 Chancelet Court, Rockville, Md. 20852</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Fort Lincoln Cemetery</b>		20c. LOCATION — City or Town, State <b>Brentwood, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, Md. 20781</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. <b>CORONARY ARTERY DISEASE</b> YRS							
b. <b>PNEUMONIA</b> DAYS							
c. <b>HYPERTENSION</b> YRS							
d. <b>Respiratory difficulty</b> DAYS							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Pritham S. Samal</i>				29c. LICENSE NUMBER <b>D28998</b>		29d. DATE SIGNED (Month, Day, Year) <b>2-11-91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>PRITHAM S. SAMAL MD 9101 CHERRY LAUREL MD 20708</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 19 '91</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 05970

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>LONNIE BLACKSHEAR</b>		2. DATE OF DEATH MONTH <b>02</b> DAY <b>15</b> YEAR <b>91</b>		3. TIME OF DEATH <b>11 15</b> M
4. SOCIAL SECURITY NUMBER <b>453-36-9415</b>	5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>60</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>03-30-1930</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Houston, Texas</b>		9. FACILITY NAME (If not institution, give street and number) <b>Holy Cross Hospital</b>		
10. CITY, TOWN OR LOCATION OF DEATH <b>Silver Spring</b>		11. COUNTY OF DEATH <b>Montgomery</b>		
12. RESIDENCE OF DECEDENT 10a. STATE <b>Maryland</b> 10b. COUNTY <b>Montgomery</b> 10c. CITY, TOWN OR LOCATION <b>Silver Spring</b> 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO 10e. STREET AND NUMBER <b>1401 Blair Mill Rd #1010</b> 10f. ZIP CODE <b>20910</b> 10g. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>				
13. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		14. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>19 Jan 1951 - 26 July 1956</b>		15. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: <b>Black</b>
16. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>0-12</b> College (1-4 or 5+) <b>3 yrs</b>		17. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Salesman</b>		18. KIND OF BUSINESS/INDUSTRY <b>Self employed</b>
19. FATHER'S NAME (First, Middle, Last) <b>Willie Blackshear</b>		20. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Henretta Roberts</b>		
21. INFORMANT'S NAME (Type/Print) <b>Lois R. Blackshear</b>		22. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1401 Blair Mill Rd #1010, Silver Spring, MD 20910</b>		
23. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		24. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Maryland Veterans</b>		25. LOCATION — City or Town, State <b>Cheltenham, MD</b>
26. SIGNATURE OF FUNERAL SERVICE LICENSEE 		27. NAME AND ADDRESS OF FACILITY <b>Austin Royster Funeral Home 3605 14th Street NW, Wash. DC</b>		
28. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <b>CARDIO-RESPIRATORY ARREST</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>MULTIPLE SYSTEM FAILURE</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>HEPATOCELLULAR CARCINOMA OF THE LUNG</b> DUE TO (OR AS A CONSEQUENCE OF): d. <b>HUMAN IMMUNE DEFICIENCY SYNDROME</b>				Approximate Interval Between Onset and Death
29. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>END STAGE RENAL DISEASE.</b> <b>MAL ABSORPTION -</b> <b>GASTROINTESTINAL BLEEDING</b>				30. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
31. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
32. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		33. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
34. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		35. DATE OF INJURY (Month, Day, Year)	36. TIME OF INJURY <b>M</b>	37. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
38. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		39. DESCRIBE HOW INJURY OCCURRED		
40. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
41. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
42. SIGNATURE AND TITLE OF CERTIFIER 		43. LICENSE NUMBER <b>D23177</b>		44. DATE SIGNED (Month, Day, Year) <b>2/15/91</b>
45. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MARIO D. BELLE DONNE</b>				
46. DATE FILED (Month, Day, Year) <b>2/21/91</b>		47. REGISTRAR'S SIGNATURE 		

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 05971

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>DONALD EUGENE BAKER</b>				2. DATE OF DEATH MONTH DAY YEAR <b>February 25, 1991</b>		3. TIME OF DEATH <b>6:00 a.m.</b>	
4. SOCIAL SECURITY NUMBER <b>216-22-8888</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>62</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>2/29/1928</b>	
8. BIRTHPLACE (State or Foreign Country) <b>MD</b>				9. COUNTY OF DEATH <b>Sabillasville</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>16752 Raven Rock Road</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Cascade</b>		9c. COUNTY OF DEATH <b>Washington</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MD</b>		10b. COUNTY <b>Washington</b>		10c. CITY, TOWN OR LOCATION <b>Cascade</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>16752 Raven Rock Road</b>				10f. ZIP CODE <b>21719</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>no war</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b></b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Machinist</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Truck Mfg.</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Calvin L. Baker</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Rose Mae Hartle</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Dorothy J. Baker</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>16752 Raven Rock Road, Cascade, MD 21719</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Green Hill Cemetery</b>		20c. LOCATION — City or Town, State <b>Waynesboro, PA 17268</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James A. Bowser</i>				22. NAME AND ADDRESS OF FACILITY <b>Grove Funeral Home, Inc. 50 S. Broad Street, Waynesboro, PA 17268</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. metastatic melanoma</b> DUE TO (OR AS A CONSEQUENCE OF): Sequently ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate interval Between Onset and Death <b>year</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Undetermined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Gregory Lyon-Loftus M.D.</i>				29c. LICENSE NUMBER <b>PA MD 030 928E</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/26/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Gregory Lyon-Loftus M.D. 6155 Anthony Highway Waynesboro, PA 17268</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 27 '91</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be attached to the certificate for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 05972

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Beatrice W. Bunting				2. DATE OF DEATH MONTH DAY YEAR February 17 1991		3. TIME OF DEATH 1515 M	
4. SOCIAL SECURITY NUMBER 218-09-4936		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 74 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept. 21 1916	
8. BIRTHPLACE (State or Foreign Country) Delaware				9a. FACILITY NAME (If not institution, give street and number) PENINSULA GENERAL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY	
9c. COUNTY OF DEATH WICOMICO				10a. STATE MD		10b. COUNTY Wicomico	
10c. CITY, TOWN OR LOCATION Pittsville				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER Rt.1 Box 195	
10f. ZIP CODE 21850				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 10				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Seamstress		16b. KIND OF BUSINESS/INDUSTRY Garment	
17. FATHER'S NAME (First, Middle, Last) Thomas Watson				18. MOTHER'S NAME (First, Middle, Maiden Surname) Annie Parsons			
19a. INFORMANT'S NAME (Type/Print) Oscar D. Bunting				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rt.1 Box 195, Pittsville, MD 21850			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Bishopville Cemetery		20c. LOCATION — City or Town, State Bishopville, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Charles W. Hart</i>				22. NAME AND ADDRESS OF FACILITY Hastings Funeral Home Selbyville, DE 19975			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Coronary Artery</i> Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <i>Primary Ventricular Fibrillation, Sudden</i> c. d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 28d. DESCRIBE HOW INJURY OCCURRED 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Donald M. Wood MD</i> 29c. LICENSE NUMBER W3311 29d. DATE SIGNED (Month, Day, Year) 2/17/91 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) P-H-M-C DONALD M. WOOD LOCUST + QUINCY ST. SALISBURY MD 21801 31. DATE FILED (Month, Day, Year) FEB 19 1991 32. REGISTRAR'S SIGNATURE <i>John E. ...</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. It is to be maintained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Annals of the

1875



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>GEORGE W. BELL</b>		2. DATE OF DEATH MONTH <b>FEBRUARY</b> DAY <b>23</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>1330</b> <input checked="" type="checkbox"/> M	
4. SOCIAL SECURITY NUMBER <b>218-05-3064</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>97</b> YRS.	
9a. FACILITY NAME (If not institution, give street and number) <b>PENINSULA GENERAL HOSPITAL</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>SALISBURY</b>		9c. COUNTY OF DEATH <b>WICOMICO</b>	
RESIDENCE OF DECEDENT					
10a. STATE <b>MD.</b>		10b. COUNTY <b>SOMERSET</b>		10c. CITY, TOWN OR LOCATION <b>WESTOVER</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER <b>STAR RT. # 2</b>		10f. ZIP CODE <b>21871</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>ARMY 1911-1914</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>STEELWORKER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>BETHELHEM STEEL</b>	
17. FATHER'S NAME (First, Middle, Last) <b>UNKNOWN</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>UNKNOWN</b>			
19a. INFORMANT'S NAME (Type/Print) <b>GEORGE BELL</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1923 FRAMES RD., BALTIMORE, MD. 21222</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>WICOMICO MEM. PARK</b>		20c. LOCATION — City or Town, State <b>SALISBURY, MD.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Gerald C. Brundage</i>		22. NAME AND ADDRESS OF FACILITY <b>BOUNDS FUNERAL HOME, SALISBURY, MD.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CARDIAC ARREST</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <div style="display: flex; align-items: center;"> <div style="font-size: 3em; margin-right: 10px;">{</div> <div>           b. <b>Subarachnoid hemorrhage</b>            c. <b>Demerol</b>            d. <b>Bladder cancer</b> </div> </div>					Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO
					24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Wm. Robbins</i>		29c. LICENSE NUMBER <b>D29349</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/23/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Wm. Robbins Civic + Route 50 Salisbury Md. 21801</b>					
31. DATE FILED (Month, Day, Year) <b>FEB 26 '91</b>		32. REGISTRAR'S SIGNATURE <i>J. Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21201-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be attached for use in the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 05974

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ARTHUR D. Berk		2. DATE OF DEATH MONTH DAY YEAR 2 21 91		3. TIME OF DEATH 0348 a M	
4. SOCIAL SECURITY NUMBER 155-09-7268		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 75 YRS.	
7. DATE OF BIRTH (Month, Day, Year) 12-7-1915		8. BIRTHPLACE (State or Foreign Country) NEW JERSEY			
9a. FACILITY NAME (If not institution, give street and number) PENINSULA GENERAL HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY		9c. COUNTY OF DEATH WICOMICO
RESIDENCE OF DECEDENT					
10a. STATE MD.		10b. COUNTY WICOMICO		10c. CITY, TOWN OR LOCATION PARSONSBURG	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER P.O. BOX 205			10f. ZIP CODE 21849		10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: WHITE					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) MECHANIC		16b. KIND OF BUSINESS/INDUSTRY AUTOMOTIVE	
17. FATHER'S NAME (First, Middle, Last) JOHN G. BERK			18. MOTHER'S NAME (First, Middle, Maiden Surname) ROSE THOMPSON		
19a. INFORMANT'S NAME (Type/Print) CHERYL BERK			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. BOX 205, PARSONSBURG, MD. 21849		
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) PARSONS CEMETERY		20c. LOCATION — City or Town, State SALISBURY, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Gerald P. Brunel</i>		22. NAME AND ADDRESS OF FACILITY BOUNDS FUNERAL HOME, SALISBURY, MARYLAND			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. cardiac arrest DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST					Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic obstructive pulmonary disease.					24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
					24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide a <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Ignatius L. D. ...</i>				29c. LICENSE NUMBER D31546	
29d. DATE SIGNED (Month, Day, Year) 2/21/91					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Ignatius L. D. ...					
31. DATE FILED (Month, Day, Year) FEB 22 '91		32. REGISTRAR'S SIGNATURE <i>Julia Davidson ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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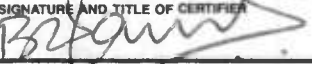
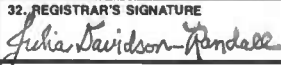
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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Clifton Calvin Baker</b>				2. DATE OF DEATH MONTH <b>02</b> DAY <b>22</b> YEAR <b>91</b>		3. TIME OF DEATH <b>5:07 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>218 18 0883</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>66</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>11-10-1924</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Harford Memorial Hosp.</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Havre de Grace</b>				9c. COUNTY OF DEATH <b>Harford</b>	
10a. STATE <b>MD</b>		10b. COUNTY <b>Harford</b>		10c. CITY, TOWN OR LOCATION <b>Havre de Grace</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>140 Deaver Street</b>				10f. ZIP CODE <b>21078</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW II</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10th</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>(Ret) Patrol Boat Capt.</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Federal Government</b>			
17. FATHER'S NAME (First, Middle, Last) <b>James W. Baker</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Lillian Waton</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mrs. Margaret J. Baker</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>140 Deaver Street, Havre de Grace, MD 21078</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Angel Hill Cemetery</b>		20c. LOCATION — City or Town, State <b>Havre de Grace, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY <b>Mitchell-Smith Funeral Home, P.A. Havre de Grace, MD 21078-3197</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiac arrest. Sudden death.</b>  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <div style="display: flex; align-items: center;"> <div style="font-size: 3em; margin-right: 10px;">{</div> <div> <p>b. <b>Recent acute inf wall MI.</b></p> <p>c. <b>WM Vent. fibrillation.</b></p> </div> </div>							Approximate Interval Between Onset and Death <b>2 weeks</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  _____							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							29b. SIGNATURE AND TITLE OF CERTIFIER  <b>B.D. PAREKH M.D.</b>
29c. LICENSE NUMBER <b>D18424</b>		29d. DATE SIGNED (Month, Day, Year) <b>2-23-91</b>		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>B.D. PAREKH M.D. 1908 HARFORD RD. Fallsm MD. 21047</b>			
31. DATE FILED (Month, Day, Year) <b>FEB 25 '91</b>		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 05976

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Grace Agnes Blakeley</b>				2. DATE OF DEATH MONTH <b>2</b> DAY <b>22</b> YEAR <b>91</b>		3. TIME OF DEATH <b>935A M</b>	
4. SOCIAL SECURITY NUMBER <b>218 32 9104</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>81</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>9/11/09</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Virginia</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Harford Memorial Hosp</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Havre de Grace, Md</b>	
9c. COUNTY OF DEATH <b>Harford</b>				10a. STATE <b>MD</b>		10b. COUNTY <b>Harford</b>	
10c. CITY, TOWN OR LOCATION <b>Havre de Grace</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>3466 Old Level Road</b>	
10f. ZIP CODE <b>21078</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>8th</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>Oren E. Heckman</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mollie Elizabeth Pinkard</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mr. Raymond L. Blakeley</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3466 Old Level Road, Havre de Grace, MD 21078</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Deer Creek Harmony Cemetery</b>		20c. LOCATION — City or Town, State <b>Darlington, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>William S. Smith</b>				22. NAME AND ADDRESS OF FACILITY <b>Mitchell-Smith Funeral Home, P.A. Havre de Grace, MD 21078-3197</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiopulmonary Arrest</b>  Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Pulmonary Embolism</b> <b>Hypertensive Cardiovascular Disease</b>							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Aneurysm, Chronic</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — A1 home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Leticia S. Galvez M.D.</b>				29c. LICENSE NUMBER <b>D15994</b>		29d. DATE SIGNED (Month, Day, Year) <b>February 22, 91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>LETICIA S. GALVEZ, M.D.</b>							
31. DATE FILED (Month, Day, Year) <b>Feb 23 91</b>		32. REGISTRAR'S SIGNATURE <b>Gina Davidson-Randall</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.





ITEMS:23pt1,pt2, 27 per DOCTOR  
G-674 4/11/91 cm

91 05977

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Barbara Ann Brown</b>		2. DATE OF DEATH MONTH <b>2</b> DAY <b>19</b> YEAR <b>91</b>		3. TIME OF DEATH <b>3:28 P M</b>
4. SOCIAL SECURITY NUMBER <b>219-44-1415</b>	5. SEX <b>1</b> <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>42</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>08/26/1948</b>	
8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>				
9a. FACILITY NAME (If not institution, give street and number) <b>Memorial Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Easton</b>		9c. COUNTY OF DEATH <b>Talbot</b>
RESIDENCE OF DECEDENT				
10a. STATE <b>MARYLAND</b>	10b. COUNTY <b>DORCHESTER</b>	10c. CITY, TOWN OR LOCATION <b>CAMBRIDGE</b>		10d. INSIDE CITY LIMITS? <b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO
10e. STREET AND NUMBER <b>310 TALBOT AVENUE</b>		10f. ZIP CODE <b>21613</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
11. MARITAL STATUS <b>1</b> <input type="checkbox"/> Never Married <b>2</b> <input type="checkbox"/> Married <b>3</b> <input type="checkbox"/> Widowed <b>4</b> <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE/CAUC.</b>				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>12th</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>MANAGER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>ACCOUNTING</b>
17. FATHER'S NAME (First, Middle, Last) <b>BRADY HENRY BRADFORD</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>DORIS THOMAS</b>		
19a. INFORMANT'S NAME (Type/Print) <b>BRADY H. BRADFORD (FATHER)</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5428 WHITE HALL ROAD, CAMBRIDGE, MD. 21613</b>		
20a. METHOD OF DISPOSITION <b>1</b> <input type="checkbox"/> Burial <b>2</b> <input checked="" type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State <b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>SALISBURY CREMATORY</b> <b>2/22 1991</b>		20c. LOCATION — City or Town, State <b>SALISBURY, MARYLAND</b>
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>		22. NAME AND ADDRESS OF FACILITY <b>CURRAN FUNERAL HOME</b> <b>308 HIGH STREET, CAMBRIDGE, MD. 21613</b>		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>Shock, liver failure</b> <b>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> <b>a. Shock, liver failure</b> <b>b. Abdominal masses of large and small bowel</b> <b>c. Superior mesenteric artery thrombosis</b> <b>d. Ingestion of soap/alkali</b> <b>HEPATIC AND SPLENIC INFARCTS AND SOAP FRAGMENTS IN THE CECUM</b>				
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Thrombosis of superior mesenteric artery (peritoneal)</b> <b>Hepatic/splenic infarcts</b>				
24a. WAS AN AUTOPSY PERFORMED? <b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) <b>HOSPITAL:</b> <input type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA <b>OTHER:</b> <input type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify)		
27. MANNER OF DEATH <b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation <b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined <b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>2/20/91</b>		28b. TIME OF INJURY <b>M</b>
28c. INJURY AT WORK? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
29a. CERTIFIER (Check only one) <b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Reinhardt Samuel MD</b>		29c. LICENSE NUMBER <b>D34633</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/20/91</b>
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Reinhardt Samuel MD</b>				
31. DATE FILED (Month, Day, Year) <b>2/20/91</b>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>		



91 05978

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Burden, Norman J.</i>				2. DATE OF DEATH MONTH <i>2</i> DAY <i>22</i> YEAR <i>1991</i>		3. TIME OF DEATH <i>1655</i> M	
4. SOCIAL SECURITY NUMBER <i>219-10-4374</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		8. AGE (In yrs. last birthday) <i>64</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>July 13, 1926</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Carroll County Gen. Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Westminster</i>		9c. COUNTY OF DEATH <i>Carroll</i>	
RESIDENCE OF DECEDENT							
10a. STATE <i>Md</i>		10b. COUNTY <i>Balto.</i>		10c. CITY, TOWN OR LOCATION <i>Reisterstown</i>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <i>224 Mysticwood Rd.</i>				10f. ZIP CODE <i>21136</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <i>WW II</i>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>2</i>		18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Certified Public Accountant</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Accounting Firm</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Albert Burden</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Anna Brody</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Margaret E. Burden</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>224 Mysticwood Rd., Reisterstown, Md. 21136</i>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Evergreen Memorial Gardens</i>		20c. LOCATION — City or Town, State <i>Finksburg, Md.</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>H. J. Eckhardt</i>		22. NAME AND ADDRESS OF FACILITY <i>Eckhardt Funeral Chapel 21117 11605 Reisterstown Rd., Owings Mills, Md.</i>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cardiovascular Collaps</i> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <i>Prostate - Cancer</i> b. <i>Wide spread metastases</i> c. <i>Anemia, Hypovolemia, Uremia</i> d. <i>Anemia, Hypovolemia, Uremia</i>							Approximate Interval Between Onset and Death <i>2/5/90</i>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined					
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Harold J. Eckhardt, MD</i>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <i>2-27-91</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Farheed Sateri, MD, 342 Washington Rd, Suite 303</i>							
31. DATE FILED (Month, Day, Year) <i>2-23-91</i>		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05979

1. DECEDENT'S NAME (First, Middle, Last) <b>FRANCES L BOYLAN</b>				2. DATE OF DEATH MONTH <b>FEB</b> DAY <b>22</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>11:15A</b>					
4. SOCIAL SECURITY NUMBER <b>166-16-2333</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>72</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>9/18/18</b>		8. BIRTHPLACE (State or Foreign Country) <b>Delaware</b>			
9a. FACILITY NAME (If not Institution, give street and number) <b>105 1/2 Pennsylvania Ave.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Westminster</b>			9c. COUNTY OF DEATH <b>Carroll</b>				
RESIDENCE OF DECEDENT				10a. STATE <b>MD</b>		10b. COUNTY <b>Carroll</b>		10c. CITY, TOWN OR LOCATION <b>Westminster</b>			
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>105 1/2 Pennsylvania Ave.</b>		10f. ZIP CODE <b>21157</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b></b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>worker</b>			16b. KIND OF BUSINESS/INDUSTRY (communications) <b>C &amp; P Telephone</b>						
17. FATHER'S NAME (First, Middle, Last) <b>Frank Kuttner</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Catherine</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Mr. Dennis F. Boylan</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>105 1/2 Pennsylvania Ave. Westminster, MD</b>							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>St. John Catholic Cemetery Westminster, MD</b>			20c. LOCATION — City or Town, State <b>Westminster, MD</b>						
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Robert K. Pritts, Sr.</b>				22. NAME AND ADDRESS OF FACILITY <b>Pritts Funeral Home &amp; Chapel 412 Washington Rd., Westminster, MD</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>PNEUMONIA</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>ALZHEIMER'S DISEASE</b> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate interval Between Onset and Death <b>1 mo.</b> <b>3 YRS.</b>											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Arthur L. Pudo, MD ATTENDING PHYSICIAN</b>				29c. LICENSE NUMBER <b>D21155</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/22/91</b>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Arthur L. Pudo, MD 524-B BALTIMORE BLVD WESTMINSTER, MD 21157</b>											
31. DATE FILED (Month, Day, Year) <b>FEB 26 '91</b>				32. REGISTRAR'S SIGNATURE <b>G. J. [Signature]</b>							



91 05980

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <i>Irene Brickner Irene Brickner</i>				2. DATE OF DEATH MONTH <i>2</i> DAY <i>10</i> YEAR <i>91</i>		3. TIME OF DEATH <i>1151 A M</i>	
4. SOCIAL SECURITY NUMBER <i>140-12-3418</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>86</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>JAN. 26, 1905</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>DORCHESTER GENERAL HOSPITAL</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>CAMBRIDGE</i>		9c. COUNTY OF DEATH <i>DORCHESTER</i>	
10a. STATE <i>MARYLAND</i>		10b. COUNTY <i>DORCHESTER</i>		10c. CITY, TOWN OR LOCATION <i>EAST NEW MARKET</i>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <i>31 MAIN STREET</i>				10f. ZIP CODE <i>21631</i>		10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>WHITE</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>5</i> College (1-4 or 5+) <i>—</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>HOMEMAKER</i>		16b. KIND OF BUSINESS/INDUSTRY <i>—</i>			
17. FATHER'S NAME (First, Middle, Last) <i>CHARLES LAUCK</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>SUSIE KIMMEY</i>			
19a. INFORMANT'S NAME (Type/Print) <i>BETTY DAYTON</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>P. O. BOX 3, EAST NEW MARKET, MD 21631</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <i>EAST NEW MARKET CEMETERY</i>		20c. LOCATION — City or Town, State <i>EAST NEW MARKET, MD</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Samuel D. Zeller</i>				22. NAME AND ADDRESS OF FACILITY <i>ZELLER FUNERAL HOME</i> <i>P. O. BOX 207, EAST NEW MARKET, MD 21631</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cardiac Arrhythmia</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <i>Hyper tension</i> DUE TO (OR AS A CONSEQUENCE OF): <i>Hypertension</i> b. <i>—</i> DUE TO (OR AS A CONSEQUENCE OF): <i>—</i> c. <i>—</i> DUE TO (OR AS A CONSEQUENCE OF): <i>—</i> d. <i>—</i> DUE TO (OR AS A CONSEQUENCE OF): <i>—</i>							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Anxiety disorder</i> Anxiety disorder							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>M. J. Feldman MD</i>				29c. LICENSE NUMBER <i>826388</i>		29d. DATE SIGNED (Month, Day, Year) <i>2-10-91</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Michael J. Feldman MD 500 Collins Hurdock rd 21643</i>							
31. DATE FILED (Month, Day, Year) <i>FEB 20 '91</i>		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Page 5 should be detached for use as the burial-transit permit. Pages 1-4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

08020 10



91 05981

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>KATHERINE B. BARONIAK</b>				2. DATE OF DEATH MONTH DAY YEAR <b>FEB. 11, 1991</b>				3. TIME OF DEATH <b>0103 A.M. M</b>					
4. SOCIAL SECURITY NUMBER <b>578-54-0725</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>78</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) <b>OCT. 30, 1912</b>		8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>NAVAL HOSPITAL</b>						9b. CITY, TOWN OR LOCATION OF DEATH <b>PATUXENT RIVER</b>				9c. COUNTY OF DEATH <b>ST. MARY'S CO.</b>			
RESIDENCE OF DECEDENT													
10a. STATE <b>MD.</b>		10b. COUNTY <b>ST. MARY'S COUNTY</b>		10c. CITY, TOWN OR LOCATION <b>ST. MARY'S CITY</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER <b>GENERAL DELIVERY</b>						10f. ZIP CODE <b>20686</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>6 YEARS</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>SCHOOL TEACHER</b>				16b. KIND OF BUSINESS/INDUSTRY <b>PUBLIC SCHOOLS</b>					
17. FATHER'S NAME (First, Middle, Last) <b>JOHN FRANK BARONIAK</b>						18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ANNA MATTEY</b>							
19a. INFORMANT'S NAME (Type/Print) <b>EDWARD R. BARONIAK</b>						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>GENERAL DELIVERY, ST. MARY'S CITY, MD. 20686</b>							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>TRINITY EPISCOPAL CEMETERY</b>				20c. LOCATION — City or Town, State <b>ST. MARY'S CITY, MD.</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael L. Gardiner</i>						22. NAME AND ADDRESS OF FACILITY <b>MATTINGLEY-GARDINER FUNERAL HOME, P.A. P.O. BOX 270, LEONARDTOWN, MD. 20650</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Probable Myocardial Infarction</b>													
DUE TO (OR AS A CONSEQUENCE OF):													
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST													
DUE TO (OR AS A CONSEQUENCE OF):													
DUE TO (OR AS A CONSEQUENCE OF):													
DUE TO (OR AS A CONSEQUENCE OF):													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO													
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER <i>William Boyd II</i>						29c. LICENSE NUMBER <b>D 14285</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/11/91</b>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>WILLIAM D. BOYD, II. M.D. LEONARDTOWN, MARYLAND 20650</b>													
31. DATE FILED (Month, Day, Year) <b>FEB 12 91</b>				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 05982

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Anna Elizabeth Bangle</i>		2. DATE OF DEATH MONTH <i>2</i> DAY <i>21</i> YEAR <i>91</i>		3. TIME OF DEATH <i>1:20 A</i>	
4. SOCIAL SECURITY NUMBER <i>215-34-5664</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>71</i> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <i>April 30, 1919</i>		8. BIRTHPLACE (State or Foreign Country) <i>Maryland</i>			
9a. FACILITY NAME (If not institution, give street and number) <i>Fallston General Hospital</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Fallston</i>		9c. COUNTY OF DEATH <i>Harford</i>	
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Harford</i>		10c. CITY, TOWN OR LOCATION <i>Edgewood</i>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <i>905 Edgewood Road</i>		10f. ZIP CODE <i>21040</i>	
10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i> <i>7</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Head Cook</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Restaurant</i>	
17. FATHER'S NAME (First, Middle, Last) <i>Hamilton (nmn) Frank, Sr.</i>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Fannie Mae Weaver</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Betty M. Lowe</i>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>13 N. Reed St., Bel Air, Md. 21014</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Trinity Lutheran Church Cem. 2-23-91 Joppa, Md.</i>		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Howard K. McComas III</i>		22. NAME AND ADDRESS OF FACILITY <i>Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, Md. 21009</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Metastatic Carcinoma to Liver; Liver Failure</i>  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF):  b. DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d. DUE TO (OR AS A CONSEQUENCE OF):		Approximate Interval Between Onset and Death <i>6 months</i>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>ASA with intermittent arrhythmia Embolism to R iliac-femoral arteries</i>		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>William P. Amos</i>		29c. LICENSE NUMBER <i>D04354</i>	
29d. DATE SIGNED (Month, Day, Year) <i>2/21/91</i>		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>William P. Amos, 2303 Bel Air Rd Fallston, Md 21047</i>			
31. DATE FILED (Month, Day, Year) <i>FEB 21 '91</i>		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 6 and 7 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



DMMH-16 Rev 1/89



91 05984

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Ruth L. Ball				2. DATE OF DEATH MONTH DAY YEAR 2-18-91				3. TIME OF DEATH 3:44 p. m.	
4. SOCIAL SECURITY NUMBER 214-34-7280		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 55 YRS.		7. DATE OF BIRTH (Month, Day, Year) 12-13-35		8. BIRTHPLACE (State or Foreign Country) Md.	
9a. FACILITY NAME (If not institution, give street and number) Edw.W.McCready Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Crisfield				9c. COUNTY OF DEATH Somerset	
RESIDENCE OF DECEDENT									
10a. STATE Maryland		10b. COUNTY Somerset		10c. CITY, TOWN OR LOCATION Crisfield				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER RT-1 Box 219-B				10f. ZIP CODE 21817		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Laborer		16b. KIND OF BUSINESS/INDUSTRY Rubberset Corp.			
17. FATHER'S NAME (First, Middle, Last) Mervin D. Christy				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mable P. White					
19a. INFORMANT'S NAME (Type/Print) Terry Ann Ball				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) RT-1 Box 219-B Crisfield Md. 21817					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) 2-23-91				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Asbury Cemetery		20c. LOCATION — City or Town, State Lawsonia Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Anthony E. Ward</i>				22. NAME AND ADDRESS OF FACILITY Anthony Ward, Cove St., Crisfield, Md.					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive Heart Failure, Decompensated DUE TO (OR AS A CONSEQUENCE OF): b. Congestive Cardiomyopathy DUE TO (OR AS A CONSEQUENCE OF): c. Hypertensive Heart Disease DUE TO (OR AS A CONSEQUENCE OF): d. Essential Hypertension Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death 1 day 1 year 5 years 20 years	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Insulin Dependent Diabetes Mellitus Myocardial Infarctions, 1985 and 7/28/89								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO								26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. DESCRIBE HOW INJURY OCCURRED			
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. Gregorio Belloso</i>	
29c. LICENSE NUMBER D-29505				29d. DATE SIGNED (Month, Day, Year) 2-19-91					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Gregorio Belloso, McCready Hospital, Crisfield, Md. 21817									
31. DATE FILED (Month, Day, Year) FEB 20 91				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>					

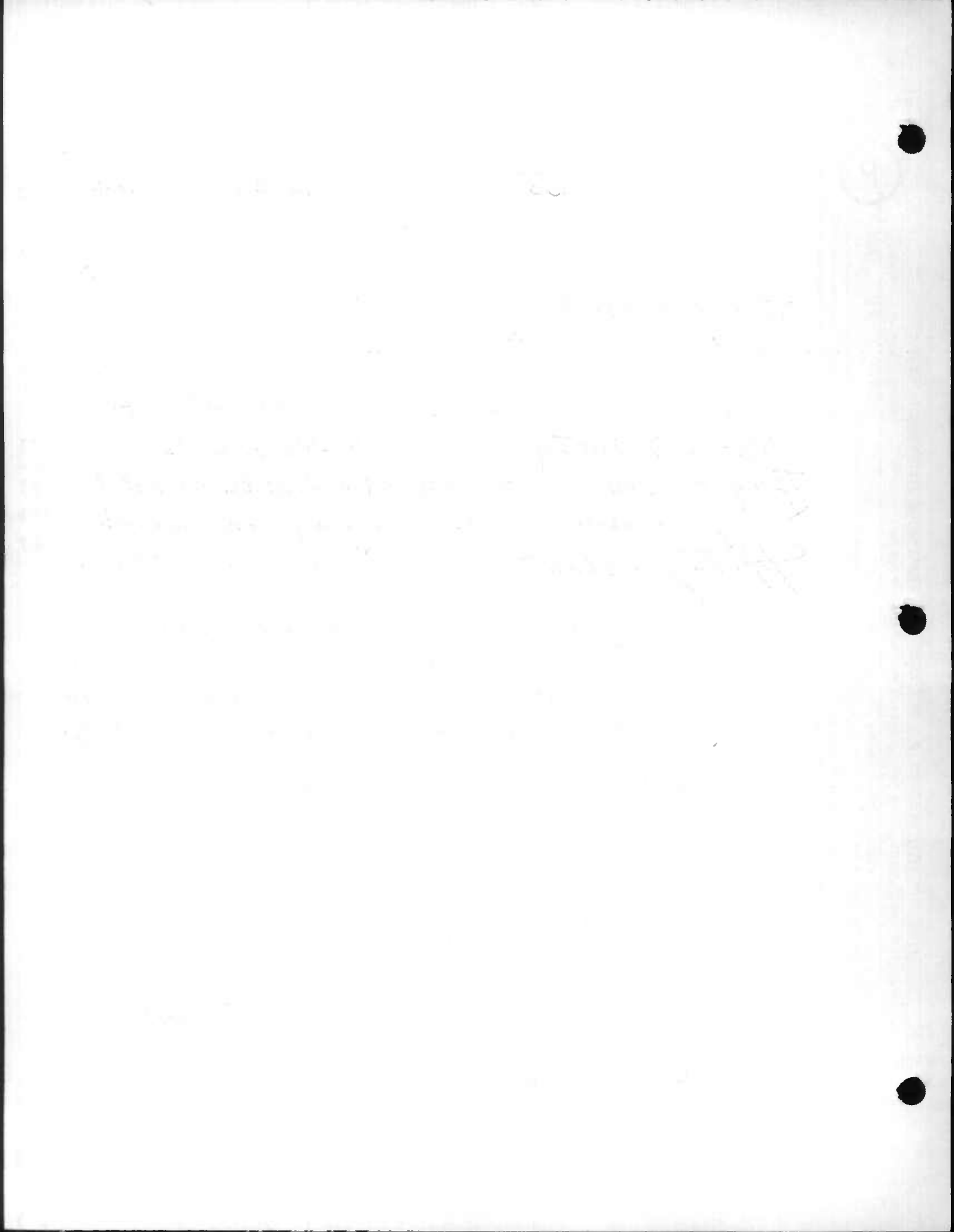
TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





91 05985

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ELIZABETH A. BELFOURE</b>				2. DATE OF DEATH MONTH DAY YEAR <b>February 21, 1991</b>		3. TIME OF DEATH <b>11:25 a m</b>	
4. SOCIAL SECURITY NUMBER <b>216-18-1963</b>		5. SEX 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>73</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>08-09-1917</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Memorial Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Cumberland</b>		9c. COUNTY OF DEATH <b>Allegany</b>	
RESIDENCE OF DECEDENT				10a. STATE <b>MD</b>		10b. COUNTY <b>Allegany</b>	
10c. CITY, TOWN OR LOCATION <b>Cumberland,</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER <b>12501 Bowling Street</b>				10f. ZIP CODE <b>21502</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>owner &amp; operator</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Bowling Green Market</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Lloyd Newman</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Virginia Robinette</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mrs. Tammy L. Ackerman</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Cumberland, MD 21502</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>SS Peter Paul Cemetery</b>		DATE		20c. LOCATION — City or Town, State <b>Cumberland Allegany</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James F. Scarpelli</i>				22. NAME AND ADDRESS OF FACILITY <b>Scarpelli Funeral Home Cumberland, MD 21502</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cong. Ca</b>  Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): <b>Asp. failure</b> b. DUE TO (OR AS A CONSEQUENCE OF): <b>COPD</b> c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate interval between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Anemia</b>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)	
28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. Victor Poonai</i>				29c. LICENSE NUMBER <b>D 36766</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/24/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Victor Poonai-955 Frederick Street-Cumberland, MD 21502</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 25 1991</b>				32. REGISTRAR'S SIGNATURE <i>Johanna Anderson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR:

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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91 05986

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ALFRED I. BLAND</b>		2. DATE OF DEATH MONTH DAY YEAR <b>February 18, 1991</b>		3. TIME OF DEATH <b>6:47 PM</b>	
4. SOCIAL SECURITY NUMBER <b>219-14-5929</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>65</b> YRS.	
7a. FACILITY NAME (If not institution, give street and number) <b>Memorial Hospital</b>		7b. CITY, TOWN OR LOCATION OF DEATH <b>Cumberland</b>		7c. COUNTY OF DEATH <b>Allegany</b>	
8a. RESIDENCE OF DECEDENT 10a. STATE <b>MD</b>		10b. COUNTY <b>Allegany</b>		10c. CITY, TOWN OR LOCATION <b>Cumberland</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>210 Arch Street</b>		10f. ZIP CODE <b>21502</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW II</b>	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>12</b>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>retired employee</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Capital Bowling Lanes</b>		17. FATHER'S NAME (First, Middle, Last) <b>John F. Bland</b>	
18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Gladys Howe</b>		19a. INFORMANT'S NAME (Type/Print) <b>Mrs. Evelyn M. Haines</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>210 Arch Street Cumberland, MD 21502</b>	
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of funeral home, cemetery, or other place) <b>Rosedale Funeral Chapel</b>		20c. LOCATION — City or Town, State <b>Martinsburg, WV</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>James J. Scarpelli</b>		22. NAME AND ADDRESS OF FACILITY <b>Scarpelli Funeral Home Cumberland, MD 21502</b>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiomyopathy</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Atherosclerotic Heart Disease</b>	
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <b>2/18/91</b>	
28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. SIGNATURE AND TITLE OF CERTIFIER <b>WBS</b>		29c. LICENSE NUMBER <b>012775</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/21/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Fiscus, Memorial Hospital Medical Bldg., Cumberland, MD 21502</b>					
31. DATE FILED (Month, Day, Year) <b>FEB 21 1991</b>		32. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Esther D. Beck</b>				2. DATE OF DEATH MONTH <b>02</b> DAY <b>17</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>1:55 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>216-22-7247</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>94</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>04-16-1896</b>	
8. BIRTHPLACE (State or Foreign Country) <b>PA</b>				9. COUNTY OF DEATH <b>Allegany</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Lions Manor Nursing Home</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Cumberland</b>		9c. COUNTY OF DEATH <b>Allegany</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MD</b>		10b. COUNTY <b>Allegany</b>		10c. CITY, TOWN OR LOCATION <b>Cumberland,</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>110 W. First Street</b>				10f. ZIP CODE <b>21502</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>12</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>former employee</b>		15b. KIND OF BUSINESS/INDUSTRY <b>Kelly-Springfield Tire Co.</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Peter Donahoe</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary V. Fisher</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mrs. Mary E. Joseph</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Cumberland, MD 21502</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>St. Marys Cemetery</b>		20c. LOCATION — City or Town, State <b>Cumberland, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>James F. Scarpelli</b>				22. NAME AND ADDRESS OF FACILITY <b>Scarpelli Funeral Home Cumberland, MD 21502</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Respiratory failure.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>b. Ily to possible aspiration</b> <b>c. C.V.A.</b> <b>d.</b>							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>V.A. Raniathan</b>				29c. LICENSE NUMBER <b>D19750</b>		29d. DATE SIGNED (Month, Day, Year) <b>2-19-91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>V. A. Raniathan, M.D. LMNH, Seton Drive, Cumberland, Maryland 21502</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 20 1991</b>		32. REGISTRAR'S SIGNATURE <b>Sonia Davidson-Randall</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>LEORA A. BITTINGER</b>				2. DATE OF DEATH MONTH <b>02</b> DAY <b>16</b> YEAR <b>91</b>		3. TIME OF DEATH <b>03:45am</b> M	
4. SOCIAL SECURITY NUMBER <b>212-54-7872</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>52</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>8/13/1938</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>SACRED HEART HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>CUMBERLAND, MD.</b>		9c. COUNTY OF DEATH <b>ALLEGANY</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Allegany</b>		10c. CITY, TOWN OR LOCATION <b>Cumberland</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>330 Pear Street</b>				10f. ZIP CODE <b>21502</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Harry R. Wilt</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Sarah A. (Wilt)</b>			
19a. INFORMANT'S NAME (Type/Print) <b>John D. Bittinger</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>330 Pear St.; Cumberland, MD 21502</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Cherry Glade Cemetery 2/18</b>		20c. LOCATION — City or Town, State <b>Accident, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>Newman Funeral Homes, P.A. Grantsville, MD 21536</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Cardiac Arrest</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. Generalized Atherosclerotic Cardiovascular disease</b> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST						Approximate Interval Between Onset and Death <b>moments</b> <b>years</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Status post aorto mesenteric surgery for occlusive arterial disease</b>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Wayne C Spiggle</i>				29c. LICENSE NUMBER <b>D11443</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/16/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR. WAYNE SPIGGLE, M.D., BMG, 912 SETON DRIVE, CUMBERLAND, MD 21502</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 20 1991</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ALMA B COOK				2. DATE OF DEATH MONTH DAY YEAR 02 18 91		3. TIME OF DEATH 1 50P M	
4. SOCIAL SECURITY NUMBER 488 24 5444		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 57 YRS.		7. DATE OF BIRTH MONTH DAY YEAR 4/2/33	
9a. FACILITY NAME (If not institution, give street and number) PRINCE GEORGE'S HOSPITAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH CHEVERLY		9c. COUNTY OF DEATH PRINCE GEORGE'S	
10a. STATE Maryland				10b. COUNTY PG		10c. CITY, TOWN OR LOCATION Landover	
10e. STREET AND NUMBER 221 63 St, NE Washington, DC				10f. ZIP CODE 20019		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Domestic		16b. KIND OF BUSINESS/INDUSTRY Private	
17. FATHER'S NAME (First, Middle, Last) Clyde Moore				18. MOTHER'S NAME (First, Middle, Maiden Surname) Janie Moore			
19a. INFORMANT'S NAME (Type/Print) Dorothy Bittle				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 221 63 St, N.E Washington, DC			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Harmony Memorial Park		20c. LOCATION — City or Town, State Landover Md			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY Dudley, S Fun Home 3200 Rhode island Ave Mt Rainier Md			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>metastatic carcinoma of the breast</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. c. d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Dehydration. Hypercalcemia</u>						Approximate Interval Between Onset and Death 5yrs	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> Attending Physician				29c. LICENSE NUMBER D20071		29d. DATE SIGNED (Month, Day, Year) 2/20/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 10300 Greenbelt Rd. Bethesda, MD, 20706 DON H. YABLONOWITZ, MD							
31. DATE FILED (Month, Day, Year) FEB 21 91 <i>[Signature]</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, &amp; 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Betty Jeane COLEMAN</b>				2. DATE OF DEATH MONTH DAY YEAR <b>February 9, 1991</b>		3. TIME OF DEATH <b>11:15 AM</b>	
4. SOCIAL SECURITY NUMBER <b>578-40-2276</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>61</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>02/07/30</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Doctors' Community Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Lanham</b>		9c. COUNTY OF DEATH <b>Prince George's</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Prince George's</b>		10c. CITY, TOWN OR LOCATION <b>East Riverdale</b>	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER <b>6602 Hillwood Drive</b>				10f. ZIP CODE <b>20737</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>-----</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>	
17. FATHER'S NAME (First, Middle, Last) <b>John Rempfer</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Grace Platt</b>			
19a. INFORMANT'S NAME (Type/Print) <b>James H. Coleman</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6602 Hillwood Drive, East Riverdale, MD 20737</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Ft. Lincoln Cemetery 2/13/91</b>		20c. LOCATION — City or Town, State <b>Brentwood, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Francis Gasch</i>				22. NAME AND ADDRESS OF FACILITY <b>Francis Gasch's Sons Funeral Home, PA 4739 Baltimore Ave., Hyattsville, MD 20781</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiac arrest.</b>  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. <b>Ca of cardio c metaplasia to pericard.</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Leukemia</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>Leukemia</b> DUE TO (OR AS A CONSEQUENCE OF): d. <b>Leukemia</b> DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>V. Severinsky, M.D.</i>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>2/10/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>10904 Decker Rd Lithia Springs MD 20901 V. Severinsky, M.D.</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 19 '91</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rendall</i>			

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

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REG. U.S. PAT. & TM. OFF. M. G. L. G. H. B. O. D.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Clarence A. Cross</b>		2. DATE OF DEATH MONTH <b>27</b> DAY <b>91</b> YEAR <b>706A</b>		3. TIME OF DEATH <b>7:06 A.M.</b>
4. SOCIAL SECURITY NUMBER <b>214-34-9288-A</b>	5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>53</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>Oct. 2, 1937</b>	8. BIRTHPLACE (State or Foreign Country) <b>Wash.</b>
9a. FACILITY NAME (If not institution, give street and number) <b>Washington County Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Hagerstown</b>		9c. COUNTY OF DEATH <b>Washington</b>
10a. STATE <b>Md.</b>		10b. COUNTY <b>Washington</b>		10c. CITY, TOWN OR LOCATION <b>Keedysville</b>
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>3409 Chestnut Grove Road</b>		
10f. ZIP CODE <b>21756</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>Elem.</b> College (1-4 or 5+)		
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Carpenter</b>		16b. KIND OF BUSINESS/INDUSTRY		
17. FATHER'S NAME (First, Middle, Last) <b>Clarence I. Cross</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Eleanor MNM Miner</b>		
19a. INFORMANT'S NAME (Type/Print) <b>Nancy R. Starliper</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3409 Chestnut Grove Rd. Keedysville, Md. 21756</b>		
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Smithburg Crematory</b>		20c. LOCATION — City or Town, State <b>Smithburg, Md.</b>
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Dennis P. Davis</b>		22. NAME AND ADDRESS OF FACILITY <b>Watson Funeral Home, 24 W. Bethel St. Hagerstown, Md. 21740</b>		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Auto Respiratory Distress</b> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF) b. DUE TO (OR AS A CONSEQUENCE OF) c. DUE TO (OR AS A CONSEQUENCE OF) d.				Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY <b>M</b>	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. SIGNATURE AND TITLE OF CERTIFIER <b>[Signature]</b>		29c. LICENSE NUMBER <b>MD 004</b>		29d. DATE SIGNED (Month, Day, Year) <b>2-27-91</b>
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>ER. 404 A12A00K 302 NW Overland, 2100 Hagerstown</b>				
31. DATE FILED (Month, Day, Year) <b>2-28-91</b>		32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>		

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 05992

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) GEORGE EDWARD Collick				2. DATE OF DEATH MONTH DAY YEAR February 18, 1991		3. TIME OF DEATH 0210 M				
4. SOCIAL SECURITY NUMBER 228-26-2822		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 61 YRS.		7. DATE OF BIRTH (Month, Day, Year) JULY 25, 1929		8. BIRTHPLACE (State or Foreign Country) PHILA. PA.		
9a. FACILITY NAME (If not institution, give street and number) PENINSULA GENERAL HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY			9c. COUNTY OF DEATH WICOMICO			
10a. STATE MD.			10b. COUNTY WORCESTER		10c. CITY, TOWN OR LOCATION BERLIN			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER 10105 GERMANTOWN ROAD				10f. ZIP CODE 21811		10g. CITIZEN OF WHAT COUNTRY? USA				
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: BLACK			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) HIGH SCH. College (1-4 or 5 +) College (1-4 or 5 +)			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LABORER			16b. KIND OF BUSINESS/INDUSTRY SUPER FRESH MARKET				
17. FATHER'S NAME (First, Middle, Last) UNKNOWN				18. MOTHER'S NAME (First, Middle, Maiden Surname) HESTER COLLICK						
19a. INFORMANT'S NAME (Type/Print) ERNESTINE COLLICK				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) ADDRESS SAME AS ABOVE						
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) NEW BETHEL UM			20c. LOCATION — City or Town, State BERLIN, MD.					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Loretta B. Jolley				22. NAME AND ADDRESS OF FACILITY JOLLEY MEMORIAL CHAPEL, RTE. 2, BOX 920 SALISBURY, MD. 21801						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory Failure 2' to Due to (OR AS A CONSEQUENCE OF): b. Colon Cancer with lung metastasis Due to (OR AS A CONSEQUENCE OF): c. Due to (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 6 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide			28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
			28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER Joseph A. Grasso MD						29c. LICENSE NUMBER D 20507		29d. DATE SIGNED (Month, Day, Year) 2/18/91		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Joseph A. Grasso 145 E. CARROLL ST SALISBURY MD										
31. DATE FILED (Month, Day, Year) FEB 20 '91			32. REGISTRAR'S SIGNATURE John F. ...							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21201-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and filed with the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





91 05993

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Gertrude May Carrick</u> <u>Gertrude, Alice Carrick</u>				2. DATE OF DEATH MONTH <u>2</u> DAY <u>22</u> YEAR <u>91</u>		3. TIME OF DEATH <u>11:45A</u> M	
4. SOCIAL SECURITY NUMBER <u>215-01-8417</u>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) <u>88</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>Nov. 3, 1902</u>	
9a. FACILITY NAME (If not institution, give street and number) <u>Fallston General Hospital</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>Fallston</u>		9c. COUNTY OF DEATH <u>Harford</u>	
RESIDENCE OF DECEDENT							
10a. STATE <u>Maryland</u>		10b. COUNTY <u>Harford</u>		10c. CITY, TOWN OR LOCATION <u>Joppa</u>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <u>03 Magnolia Road</u>				10f. ZIP CODE <u>21085</u>		10g. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>8</u> College (1-4 or 5+) <u>College</u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Homemaker</u>		16b. KIND OF BUSINESS/INDUSTRY <u>Home</u>			
17. FATHER'S NAME (First, Middle, Last) <u>John (nm) Battee</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Mary ——— Staaus</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Charlotte M. Hardesty</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1808 Walton Road, Edgewood, Md. 21040</u>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Bel Air Memorial Gardens 2-25-91</u>		20c. LOCATION — City or Town, State <u>Bel Air, Md.</u>		20d. DATE <u>2-25-91</u>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Howard K. McComas III</u>				22. NAME AND ADDRESS OF FACILITY <u>Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Md. 21009</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>SEPTICEMIA</u>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF):  b. DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d.							Approximate Interval Between Onset and Death <u>6 wks.</u>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>GI BLEEDING, DIHYDROARTERIAL HYPERTENSION, ANEMIA</u>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <u>1</u>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>William M.D.</u>				29c. LICENSE NUMBER <u>D32609</u>		29d. DATE SIGNED (Month, Day, Year) <u>2/22/91</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>KAMRUDIN MITHANI MD. 433 GIRARD ST. HAVRE DE GRAVE MD 21078</u>							
31. DATE FILED (Month, Day, Year) <u>FEB 25 '91</u>		32. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Failure to do so could be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				CERTIFICATE OF DEATH				REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last) <b>PATRICK Celeste</b>				2. DATE OF DEATH MONTH <b>2</b> DAY <b>24</b> YEAR <b>91</b>				3. TIME OF DEATH <b>4:30A M</b>							
4. SOCIAL SECURITY NUMBER <b>013-09-6760</b>				5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>77</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>2-20-1914</b>		8. BIRTHPLACE (State or Foreign Country) <b>MASS</b>					
9a. FACILITY NAME (If not institution, give street and number) <b>Stella Maris Hospice</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Towson</b>				9c. COUNTY OF DEATH <b>Baltimore</b>							
10a. STATE <b>Massachusetts</b>		10b. COUNTY <b>Plymouth</b>		10c. CITY, TOWN OR LOCATION <b>Brockton</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
10e. STREET AND NUMBER <b>55 City Hall Plaza #706</b>				10f. ZIP CODE <b>02401</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>3</b> College (1-4 or 5+) <b>3</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Sales Rep.</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Picture Frames</b>							
17. FATHER'S NAME (First, Middle, Last) <b>Joseph Celeste</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Louise Alfieri</b>											
19a. INFORMANT'S NAME (Type/Print) <b>Margaret L. Kelleher</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1508 Regent Drive Bel Air, Maryland</b>											
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Calvary Cemetery</b>				20c. LOCATION — City or Town, State <b>Brockton, Massachusetts</b>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Michael P. Marzullo</b>				22. NAME AND ADDRESS OF FACILITY <b>Marzullo Funeral Service 3981 Carrollton Road Upperco, Md. 21155</b>											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>e. bladder cancer</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>											
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)											
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Carla S. Alexander</b>								29c. LICENSE NUMBER <b>D 27087</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/24/91</b>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Carla S. Alexander, M.D.—Stella Maris Hospice-Dulaney Valley Rd.—Towson 21204</b>															
31. DATE FILED (Month, Day, Year) <b>FEB 25 '91</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>											



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, and 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 05995

1. DECEDENT'S NAME (First, Middle, Last) <b>Anna Sue Cockrum</b>				2. DATE OF DEATH MONTH DAY YEAR <b>Feb. 21 91</b>		3. TIME OF DEATH <b>8.00A<sup>M</sup></b>					
4. SOCIAL SECURITY NUMBER <b>200-18-0032</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>64</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>July 21, 1926</b>					
8. BIRTHPLACE (State or Foreign Country) <b>Virginia</b>				9a. FACILITY NAME (If not Institution, give street and number) <b>138A Old State Road</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Crisfield</b>					
9c. COUNTY OF DEATH <b>Somerset</b>				10a. STATE <b>Md.</b>		10b. COUNTY <b>Somerset</b>					
10c. CITY, TOWN OR LOCATION <b>Crisfield</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>138 A Old State Road</b>					
10f. ZIP CODE <b>21817</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced					
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2 Years</b> College (1-4 or 5+) <b>Bank Vice President</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Banking</b>		16b. KING OF BUSINESS/INDUSTRY <b>Banking</b>					
17. FATHER'S NAME (First, Middle, Last) <b>William W. Warfield</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Margaret Nolan Gibbons</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Mary T. Szwed</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>138A. Old State Road Crisfield Md 21817</b>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Greenwood Cemetery</b>		20c. LOCATION — City or Town, State <b>Knoxville, Tenn.</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Greg C. Stirling Sr.</i>				22. NAME AND ADDRESS OF FACILITY <b>Sterling Funeral Home, Crisfield, Md.</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Hepatic Failure</i></b> <b>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST</b> a. <b>Disseminated Carcinoma Liver</b> b. <b>Unknown Primary Neoplasm</b> c. <b>Malignant Melanoma (R) Leg 2 yrs. ago</b> d.								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Malignant Melanoma (R) Leg 2 yrs. ago</b>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>W. (Gru) M.D.</i>				29c. LICENSE NUMBER <b>D15715</b>		29d. DATE SIGNED (Month, Day, Year) <b>2.21.91</b>		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>William Gill M.D. 34-A BURTON AVE CRISFIELD, MD 21817</b>			
31. DATE FILED (Month, Day, Year) <b>FEB 21 '91</b>				32. REGISTRAR'S SIGNATURE <i>Julia Barron-Hendall</i>							



91 05996

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MARY E. CROCKETT</b>				2. DATE OF DEATH MONTH <b>2</b> DAY <b>13</b> YEAR <b>91</b>		3. TIME OF DEATH <b>23.23 P M</b>	
4. SOCIAL SECURITY NUMBER <b>223-08-5720</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>72</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>6/27/18</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>PENINSULA GENERAL HOSPITAL</b>				8b. CITY, TOWN OR LOCATION OF DEATH <b>SALISBURY</b>		8c. COUNTY OF DEATH <b>WICOMICO</b>	
10a. STATE <b>Virginia</b>		10b. COUNTY <b>Accomack</b>		10c. CITY, TOWN OR LOCATION <b>Tangier</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>P. O. Box 65 (Main St.)</b>				10f. ZIP CODE <b>23440</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>Grade 8</b> College (1-4 or 5+) <b>- - -</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>John Wesley Charnock</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Dora Ellen Parks</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Hettie Bowden</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P. O. Box 13 - Tangier, VA 23440</b>			
20a. METHOD OF DISPOSITION <b>02-17-91</b> <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Swain Church Cemetery</b>		20c. LOCATION — City or Town, State <b>Tangier, VA</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Robert H. Bradshaw, Jr.</b>				22. NAME AND ADDRESS OF FACILITY <b>Bradshaw &amp; Sons Funeral Home 306 W. Main St. - Crisfield, MD 21817</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CHADOPULMONARY ARREST</b> Due to (or as a consequence of): <b>ACUTE MYOCARDIAL INFARCTION</b> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>CHADOPULMONARY ARREST</b> Due to (or as a consequence of): <b>ACUTE MYOCARDIAL INFARCTION</b> Due to (or as a consequence of):							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED					
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>D. J. Gudnicki M.D.</b>				29c. LICENSE NUMBER <b>D20912</b>		29d. DATE SIGNED (Month, Day, Year) <b>2-13-91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DENNIS CHADNICKI LANCEY + LOCUST STS SALISBURY, MD 21801</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 19 '91</b>		32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY AN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death. IMPORTANT: If item 28 is marked "Other," the medical examiner must be notified at once.

First of March

for the year



91 05997

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Cora Mae Clise				2. DATE OF DEATH MONTH 2 DAY 14 YEAR 91		3. TIME OF DEATH 4:30 A.M.	
4. SOCIAL SECURITY NUMBER 213-72-2544		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 80 YRS.		7. DATE OF BIRTH (Month, Day, Year) 6/10/10	
8a. FACILITY NAME (If not institution, give street and number) FROSTBURG VILLAGE NURSING HOME				8b. CITY, TOWN OR LOCATION OF DEATH FROSTBURG		8c. COUNTY OF DEATH ALLEGANY	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY ALLEGANY		10c. CITY, TOWN OR LOCATION FROSTBURG (VALE SUMMIT)		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER RT. 1, BOX 570				10f. ZIP CODE 21532		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER		16b. KIND OF BUSINESS/INDUSTRY OWN HOME			
17. FATHER'S NAME (First, Middle, Last) THOMAS FRANK GILES				18. MOTHER'S NAME (First, Middle, Maiden Surname) LILLIE NORRINGTON			
19a. INFORMANT'S NAME (Type/Print) ERMA ANDERSON				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 319 BARNARD ST., FROSTBURG, MD 21532			
20. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) FROSTBURG MEMORIAL PARK		20c. LOCATION — City or Town, State FROSTBURG, MD 21532			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Marion M. Sowers</i>				22. NAME AND ADDRESS OF FACILITY SOWERS FUNERAL HOME 60 W. MAIN ST., FROSTBURG, MD 21532			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Coronary Heart Failure</i>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <i>Coronary Artery Disease</i> <i>Diabetes mellitus</i> <i>Cerebral Infarction</i>							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Normal pressure hydrocephalus</i> <i>Hypothyroidism</i>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> D.O.A. OTHER: 4 <input checked="" type="checkbox"/> Nursing home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined					
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Chang H. Oh, M.D.</i>				29c. LICENSE NUMBER D24951		29d. DATE SIGNED (Month, Day, Year) 2/15/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Chang H. Oh, M.D., 48 Tarn Terrace, Suite 204, Frostburg, Md. 21532							
31. DATE FILED (Month, Day, Year) FEB 20 1991				32. REGISTRAR'S SIGNATURE <i>Julian Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146


TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 05998

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>LUCILLE Elise DE MAURY</b>		2. DATE OF DEATH MONTH DAY YEAR <b>2 18 91</b>		3. TIME OF DEATH <b>11:10 A</b>	
4. SOCIAL SECURITY NUMBER <b>577-24-7521</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>77</b> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <b>01 17 14</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>So. MARYLAND Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>CLINTON</b>		9c. COUNTY OF DEATH <b>P.B. County</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Prince George's</b>		10c. CITY, TOWN OR LOCATION <b>Clinton</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>9106 Pineview Lane</b>		10f. ZIP CODE <b>20735</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— if yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Caucasian</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>12th</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Comptomerist</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Embassy Dairy</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Ballinger S. Goldsmith</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Elise Borman</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Harry DeMaury</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12704 Lunan Road Clinton, Maryland 20735</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>St. Ignatius Church Cem. 2/21/91</b>		20c. LOCATION — City or Town, State <b>Port Tobacco Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY <b>Lee Funeral Home, Inc. 6633 Old Alexander Ferry Rd Clinton, Md 20735</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Septis</b>					
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST					
a. DUE TO (OR AS A CONSEQUENCE OF): <b>Urinary Tract Infection</b>					
b. DUE TO (OR AS A CONSEQUENCE OF):					
c. DUE TO (OR AS A CONSEQUENCE OF):					
d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CVA - 8/80 - S. hypertension - possible internal absorption - renal failure - S. chondria</b>					
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <b>R. M. ...</b>		29c. LICENSE NUMBER <b>12564</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/18/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>RS2A MORTUARY 4255 28th Ave Md 20748</b>					
31. DATE FILED (Month, Day, Year) <b>FEB 21 '91</b>		32. REGISTRAR'S SIGNATURE <b>John Davidson-Rendall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 05999

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR  
STATE  
REGISTRAR

REG. NO.

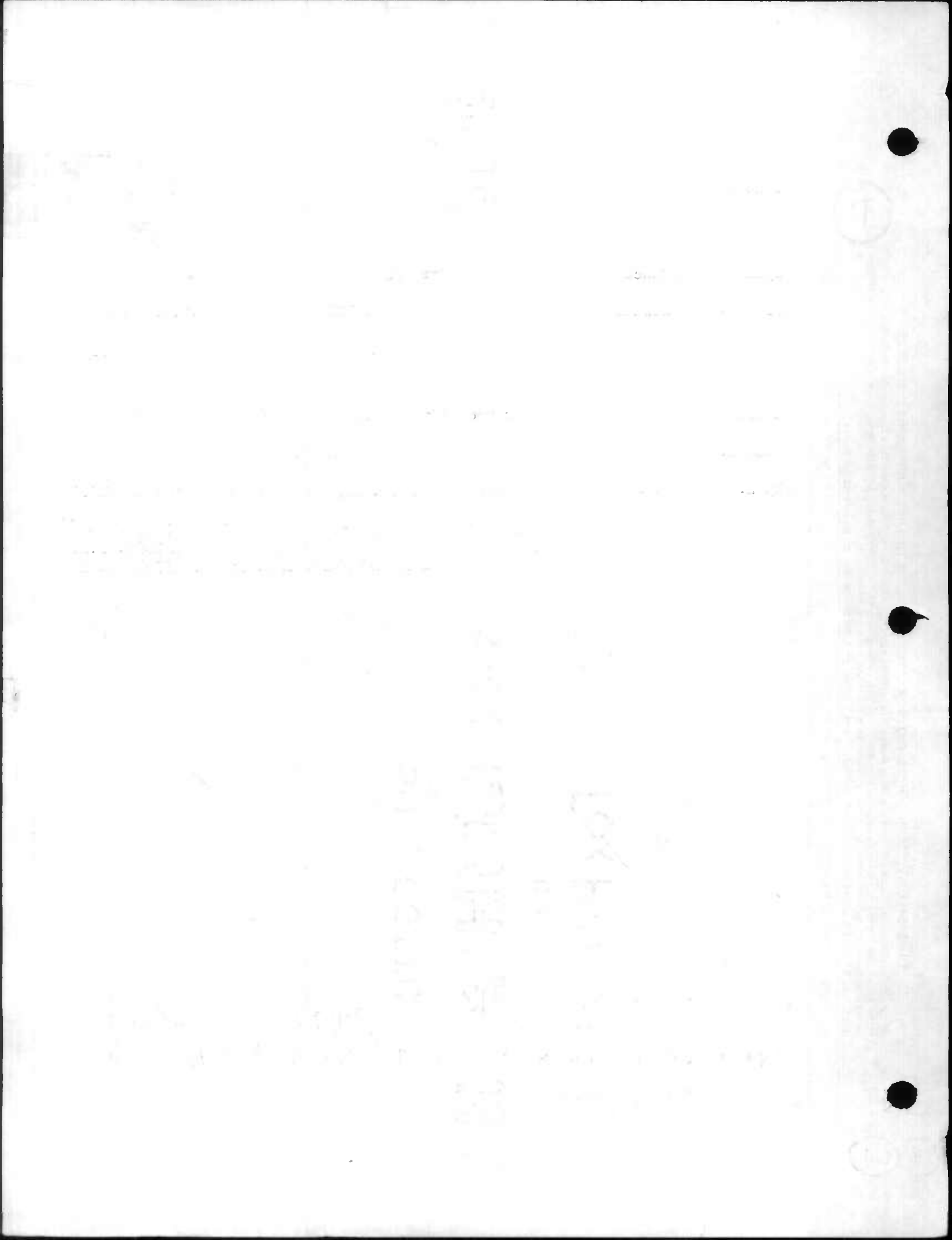
1. DECEDENT'S NAME (First, Middle, Last) <b>John Stanley DUNNING, Sr.</b>				2. DATE OF DEATH MONTH <b>02</b> DAY <b>14</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>8:11P</b> M	
4. SOCIAL SECURITY NUMBER <b>213-24-3012</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		8. AGE (In yrs. last birthday) <b>90</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>April 4, 1900</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Doctor's Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Lanham</b>		9c. COUNTY OF DEATH <b>Prince George's</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Prince George's</b>		10c. CITY, TOWN OR LOCATION <b>Colmar Manor</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>4333 Lawrence Street</b>				10f. ZIP CODE <b>20722</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>3rd Grade</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Ground Maintenance</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Park &amp; Planning Commission</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Samuel L. Dunning</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Annie L. Cardoze</b>			
19a. INFORMANT'S NAME (Type/Print) <b>John S. Dunning, Jr. (Son)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3070 Marston Road, Westminster, Maryland 21157</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Maryland State Veterans 02/20/91 Cheltenham, Maryland</b>		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Jack D. Friend</i>				22. NAME AND ADDRESS OF FACILITY <b>Cemetery Francis Gaston's Sons Funeral Home, P.A. 4739 Baltimore Ave. Hyattsville, Md. 20781</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Ante heart attack</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Arteriosclerosis heart disease</b>  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):						Approximate Interval Between Onset and Death <b>minutes</b> <b>4/11</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Calcific aortic and mitral valve disease, old myocardial infarct, old left ventricular aneurysm, other arteriosclerosis, acute coronary artery disease</b>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Frederick H. Wilhelm MD</i>				29c. LICENSE NUMBER <b>210220</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/15/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Frederick H. Wilhelm MD 5807 Annapolis Road New Annapolis, Maryland 21404</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 19 '91</b>		32. REGISTRAR'S SIGNATURE <i>Jelia Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





ITEM:6,7 per FH  
G-673 3/5/91 cm

91 06000

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Joseph Dixon</b>				2. DATE OF DEATH MONTH DAY YEAR <b>2/11 91</b>		3. TIME OF DEATH HOURS MINUTES <b>16 30</b>	
4. SOCIAL SECURITY NUMBER <b>241-62-5755</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>50</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>1/3/41</b>	
8. BIRTHPLACE (State or Foreign Country) <b>North Carolina</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Washington Adventist Hosp</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Takoma Park, MD</b>	
9c. COUNTY OF DEATH <b>Montgomery</b>				10a. STATE <b>District of Columbia</b>			
10b. COUNTY <b>Washington</b>				10c. CITY, TOWN OR LOCATION <b>Washington</b>			
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>1929 First Street, N. E.</b>			
10f. ZIP CODE <b>20002</b>				10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>12th grade</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Tractor Trailer Driver</b>		16b. KIND OF BUSINESS/INDUSTRY <b>American Van Lines</b>			
17. FATHER'S NAME (First, Middle, Last) <b>George Dixon</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Roberta Freeman</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Jan D. Dixon (nephew)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3610 - 24th Avenue, Temple Hills, Maryland 20748</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Evergreen Memorial Park</b>		20c. LOCATION — City or Town, State <b>Grifton, North Carolina</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>John W. Latney Jr.</b>				22. NAME AND ADDRESS OF FACILITY <b>Latney's Funeral Home 3831 Georgia Avenue, N.W., Wash. D.C. 20011</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Brain death</b> <b>Intracerebral bleed</b> <b>Hypertensive Encephalopathy</b> <b>Alcoholic Intoxication</b>						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) <input checked="" type="checkbox"/> HOSPITAL: Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER: Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)	
28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>John W. Latney Jr.</b>		29c. LICENSE NUMBER <b>D34765</b>		29d. DATE SIGNED (Month, Day, Year) <b>2/12/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Abdullah Riar, M.D.; 14201 Laurel Park Drive, Laurel, Maryland 20707</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 19 91</b>				32. REGISTRAR'S SIGNATURE <b>John Davidson</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIXON, JOSEPH 5403 0  
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